No. 90-97

In The

Supreme Court of the United States

October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

JOINT APPENDIX

JAMES D. HOLZHAUER
MAYER, BROWN & PLATT
190 South LaSalle Street
Chicago, Illinois 60603
(312) 782-0600

Counsel for Petitioner

KENNETH W. STARR
Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 514-2217

Counsel for the National Labor Relations Board

WOODY N. PETERSON
DICKSTEIN, SHAPIRO & MORIN
2101 L Street, N.W.
Washington, D.C. 20037
(202) 785-9700

Counsel for Respondent American Nurses Association

DAVID SILBERMAN
LAURENCE GOLD
815 16th Street
Washington, D.C. 20006
(202) 637-5390

Counsel for Respondent AFL-CIO

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The opinion of the United States Court of Appeals for the Seventh Circuit (Pet. App. 1a-16a), and the Memorandum Opinion and Order of the United States District Court for the Northern District of Illinois (Pet. App. 17a-42a) are included in the Appendix to the Petition for Writ of Certiorari.

Docket Entries

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, NO. 89-C-3279.

Filed 04/21/89:	Complaint
Minute order of 05/22/89:	The plaintiff's motion for a preliminary injunction is granted.
Minute order of 07/25/89:	The plaintiff's motion for a permanent injunction is granted. The defendant's motion for summary judgment is denied. The petition of the AFL-CIO and the American Nurses Association to intervene is granted.
Filed 07/28/89:	Defendant-Intervenors NOTICE OF APPEAL re: order dated 07/25/89 ($105.00 paid).
Filed 07/31/89:	Defendant's NOTICE OF APPEAL re: order dated 07/25/89 (NO FEE REQUIRED) NLRB.
Filed 08/01/89:	Defendant's-Intervenors AFL-CIO NOTICE OF APPEAL re: order dated 07/25/89 ($105.00 paid).

UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT, NOS. 89-2604, 89-2605, 89-2622

8/1/89	U.S. civil case docketed [89-2604 & 89-2605].
8/3/89	U.S. civil case docketed [89-2622].

8/9/89	ORDER: The court orders these appeals CONSOLIDATED for purposes of briefing and disposition: [89-2604, 89-2605, 89-2622].
4/11/90	ORDER: Final judgment, REVERSED.
5/2/90	ORDER issued GRANTING motion to stay mandate.
5/11/90	ORDER issued DENYING motion for reconsideration.

NATIONAL LABOR RELATIONS BOARD

29 CFR Part 103

Collective-Bargaining Units in the Health Care Industry

AGENCY: National Labor Relations Board.

ACTION: Notice of proposed rulemaking and notice of hearing.

SUMMARY: In order to facilitate the election process, the National Labor Relations Board proposes to amend its rules to include a new provision specifying which bargaining units will be found appropriate in various types of health care facilities. The Board has resolved to utilize notice-and-comment rulemaking rather than be presented with continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case. Interested parties may submit oral testimony in connection with the proposed rules.

DATES: Comments must be received on or before October 30, 1987.

Hearings are scheduled as follows: August 17, 1987, Washington, DC, 9:00 a.m.; August 31, 1987, Chicago, Illinois; September 14, 1987, San Francisco, California.

Persons wishing to present oral testimony at any one of the specified locations shall call or write no later than July 24, 1987.

ADDRESSES: Comments should be sent to: Office of the Executive Secretary, 1717 Pennsylvania Avenue, NW., Room 701, Washington, DC 20570, Telephone: (202) 254-9430.

The hearings will be conducted at the following locations:

(1) *Washington, DC* – The Board's Hearing Room, Sixth Floor, 1717 Pennsylvania Avenue, NW., Washington, DC 20570.

(2) *Chicago, Illinois* – Persons who wish to attend this hearing should contact either the Office of the Executive Secretary or the Board's Chicago Regional Office, Everett McKinley Dirksen Building, 219 S. Dearborn Street, Chicago, Illinois 60604, telephone number (312) 353-7570, to be notified of the exact time and place of the Chicago hearing.

(3) *San Francisco, California* – Persons who wish to attend this hearing should contact either the Office of the Executive Secretary or the Board's San Francisco Regional Office, 901 Market Street, Suite 400, San Francisco, California 94103, telephone number (415) 995-5324, to be notified of the exact time and place of the San Francisco hearing.

Persons wishing to present oral testimony at any one of the specified locations should notify the office of the Executive Secretary, 1717 Pennsylvania Ave., NW., Washington, DC 20570, telephone number (202) 254-9430.

FOR FURTHER INFORMATION CONTACT: John C. Truesdale, Executive Secretary. Telephone: (202) 254-9430.

SUPPLEMENTARY INFORMATION:

I. Background

Since 1974, when Congress extended the protection of the National Labor Relations Act to nonprofit hospitals, the Board has taken literally hundreds of thousands of pages of testimony in a myriad of litigated cases regarding particular circumstances at various health care facilities. Nonetheless, to this day there is no one, generally phrased test for determining appropriate units in this industry that has met with success in the various circuit courts of appeal, and, unfortunately, parties have no clear guidance as to what units the Board and courts will ultimately find appropriate.

At the outset, in a series of 1975 decisions, the Board found appropriate several specific types of units. For example, in *Mercy Hospitals of Sacramento*,[1] after noting the congressional admonition against "undue proliferation," the Board found appropriate a separate unit of registered nurses, finding that they possess "interests evidencing a greater degree of separateness than those possessed by most other professional employees in the health care industry." Thereafter, in *NLRB v. St. Francis Hospital of Lynwood*,[2] the Ninth Circuit rejected the *Mercy* doctrine, finding that the Board had set forth an unwarranted presumption of appropriateness in that adjudicative proceeding,[3] and, further, that the Board had

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[1] 217 NLRB 765, 767 (1975), enf. denied on other grounds 589 F.2d 968 (9th Cir. 1978) cert. denied 440 U.S. 910 (1979).

[2] 601 F.2d 404 (9th Cir. 1979).

[3] Id. at 414-417.

improperly looked for a "community of interests" rather than a "disparity of interests."[4] The Board's later *Newton-Wellesley Hospital* decision[5] represented an explicit effort by the Board to address the Ninth Circuit's concerns in *St. Francis*, but subsequent decisions based on *Newton-Wellesley* met with no greater judicial acceptance.[6] Finally, after a number of years of unsuccessfully advocating variations of the "community of interests" test with respect to registered nurses, the Board, in *North Arundel Hospital Assn.*[7] and *Keokuk Area Hospital*,[8] moved toward the Ninth Circuit's view and held that the disparity of interests test should be applied, having found in *St. Francis Hospital*[9] that that test better met the standards desired by Congress and required by the courts. Yet, recently the D.C. Circuit has severely criticized *St. Francis II*,[10] holding that the disparity test was not mandated by the legislative history, and strongly suggesting that some variation of the historically accepted community of

[4] Id. at 418-419.

[5] 250 NLRB 409 (1980).

[6] See, e.g., *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982); *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191 (4th Cir. 1982). See also *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981); *Mary Thompson Hospital v. NLRB*, 621 F.2d 858 (7th Cir. 1980).

[7] 279 NLRB No. 48 (Apr. 16, 1986).

[8] 278 NLRB No. 33 (Jan. 27, 1986).

[9] 271 NLRB 948 (1984) (*St. Francis II*).

[10] *Electrical Workers IBEW Local 474 (St. Francis Hospital) v. NLRB* 814 F.2d 697 (D.C. Cir. 1987).

interests standard was required.[11] Similarly, the Second,[12] Eighth,[13] and Eleventh Circuits,[14] while acknowledging the necessity to restrict health care units, have directly or indirectly disagreed with the disparity of interests test.

In cases involving maintenance units, the Board's decisions have, likewise, not achieved judicial acceptance. Nor have Board Members among themselves always agreed on the proper test to apply. In the first lead case, *Shriners Hospitals for Crippled Children*,[15] the Board was split three ways: two members found the requested unit of stationary engineers did not possess a "community of interest sufficiently separate and distinct" to warrant a separate unit; a third member concurred generally; and two other members found the requested unit appropriate. Thereafter, in an attempt to clarify the law in this area, the Board held a special oral argument. Consensus was not achieved. In one case, a majority of the Board found a separate maintenance unit inappropriate;[16] in another, though finding a unit of stationary engineers to

[11] As concurring Judge Buckley observed, the majority technically left open the possibility the Board was entitled to switch from the community of interests standard, but did so in "ominous tones," thereby rendering an "advisory opinion" on that matter. (Id. at 718).

[12] *Masonic Hall v. NLRB*, 699 F.2d 626 (1983).

[13] *Watonwan Memorial Hospital v. NLRB*, 711 F.2d 848, 850 (1983).

[14] *NLRB v. Walker County Medical Center*, 722 F.2d 1535, 1539 at fn. 4 (1984).

[15] 217 NLRB 806 (1975).

[16] *Jewish Hospital of Cincinnati*, 223 NLRB 614 (1976).

be appropriate, the Board relied on four different rationales.[17] The Board's treatment of this area was criticized by the Third Circuit, which held that in these cases the community of interests standard intended by Congress was a nontraditional one, and that the Board had not struck the proper balance.[18] A similar conclusion was reached by the Seventh Circuit.[19] *In Allegheny General Hospital,*[20] the Board attempted to explain more clearly its rationale in maintenance unit cases, but that effort was not accepted judicially either.[21] Board Members could agree neither on the general test to apply, nor on the correct results in particular cases.[22] A further effort at clarification was made in *St. Francis Hospital,* 265 NLRB 1025 (1982) (*St. Francis I*), which itself contained two separate dissents. Thereafter, the Board issued the aforementioned *St. Francis II* decision, attempting to apply the disparity test so as, it said, better to follow Congress' admonition against undue proliferation. As noted, the D.C. Circuit found that that decision itself represented a misreading of the statute.

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[17] *St. Vincent's Hospital,* 223 NLRB 638 (1976).

[18] *St. Vincent's Hospital v. NLRB,* 567 F.2d 588 (3d Cir. 1977).

[19] *NLRB v. West Suburban Hospital,* 570 F.2d 213 (7th Cir. 1978).

[20] 239 NLRB 872 (1978).

[21] *Allegheny General Hospital v. NLRB,* 608 F.2d 905 (3d Cir. 1979), denying enf. of 239 NLRB 872.

[22] One court stated the Board's opinions in this area were in a state of "disarray." *Long Island College Hospital v. NLRB,* 566 F.2d 833, 843–444 (2d Cir. 1977), cert. denied 435 U.S. 996 (1978).

Thirteen years and many hundreds of cases later, the Board finds that despite its numerous, well-intentioned efforts to carry out congressional intent through formulation of a general conceptual test, it is now no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974.

II. Disparity Versus Community Of Interests

In reflecting on the court opinions mentioned above, the Board notes that most courts have tended towards either a "community of interests" or "disparity of interests" test. Though these tests over the past decade or so have developed a "life of their own," and have been taken to refer to more or fewer units, respectively, we believe it appropriate to repeat an earlier Board observation in one lead case, *Newton-Wellesley Hospital,* supra, that various courts' "disagreement with our approach may be largely semantic."[23] As the Board there noted:

> The Board's inquiry into the issue of appropriate units, even in a non-health care industrial setting, never addresses, solely and in isolation, the question whether the employees in the unit sought have interests in common with one another. Numerous groups of employees fairly can be said to possess employment conditions or interests "in common." Our inquiry – though perhaps not articulated in every case – necessarily proceeds to a further determination whether the interests of the group sought are sufficiently distinct from those of other employees to warrant the establishment of a

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[23] 250 NLRB at 411-412.

> separate unit. We respectfully suggest that, at least to that extent, the test of "disparateness" described by the court is, in practice, already encompassed logically within the community-of-interest test as we historically have applied it, and, accordingly, we interpret the court's direction to the Board to be one of emphasis or degree, and not embracing a distinction of kind.

In one case, after chronicling the checkered and largely unfavorable treatment the Board's broadly stated principles have received from reviewing courts, the Second Circuit concluded that a court sometimes enforces the Board's decision if it "can infer from the Board's result that it has taken the nonproliferation policy into account."[24] The court suggested that perhaps courts "focus * * * on what the Board did as much as on what it said."[25]

The court's analysis of what the Board has done in its hithertofore "doctrinal" approach to health care unit cases was echoed in the description of this process offered by one scholarly commentator:[26]

> Rather than providing a basis for decisions that only a supposedly expert agency could make – by evaluating the available empirical, economic literature an systematically distilling the accumulated experience of Board personnel

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[24] *Masonic Hall v. NLRB*, 699 F.2d at 637.

[25] Id.

[26] Estreicher, *Policy Oscillation of the Labor Board: A Plea for Rulemaking*, in proceedings of NYU 37th Annual National Conference on Labor (1984), reprinted in 37 Ad. L. Rev. 163, 172 (1985).

> and of the labor relations community generally – the Board acts as a kind of Article I "Talmudist" court, parsing precedent, divining the true meaning of some Supreme Court ruling, and balancing in some mysterious fashion competing, yet absolute-sounding values.

The Board has decided that, rather than formulating yet another broadly phrased test for determining appropriate health care units, perhaps a new approach is needed.

III. The Decision To Engage In Rulemaking: Doctrinal Versus Empirical Approach

The focus of all appropriate unit decisions in the health care industry has been the congressional admonition against "undue proliferation." As described in detail above, some Board Members, and some courts, have believed that this permitted a "community of interests" test, with special emphasis on avoiding proliferation. Others have believed this mandated or at least suggested a "disparity of interest" test, with the same emphasis. As noted, the Second Circuit in *Masonic Hall* believed the real test was in the result reached by the Board, i.e., what unit or units were in fact found appropriate. Indeed, at the end of its decision in *Masonic Hall*, the court observed, perhaps wistfully, that "empirical data is not before us."[27]

It is clear to us that the key element in the Board's avoidance of proliferation is to designate how many units will be deemed appropriate in a particular type of health

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[27] 699 F.2d at 642.

care facility. In so doing, the Board must effectuate section 7 rights by permitting bargaining in cohesive units, units with interests both shared within the group and disparate from those possessed by others; weighed against this must be Congress' expressed desire to avoid proliferation in order to avoid disruption in patient care, unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages, and increased costs due to whipsaw strikes and wage leapfrogging.[28] Though the Board has of times made broad generalizations as to which types of unit configurations would or would not lead to proliferation and the catalogue of undesired results, it cannot be denied that it has never obtained empirical data on these matters. This, along with the still unsettled state of the Board's past, doctrinal efforts after so many years, is on major reasons for the Board's deciding to engage in rulemaking.

Another major reason is a reflection of the Board's extensive experience. The Board has in the last 13 years received many hundreds of petitions for health care units. Generally, the units requested have been in approximately six predictable groupings: registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and skilled maintenance employees.[29] Only occasionally have units of guards or physicians been sought. It is our observation that these groups of

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[28] See description of the legislative history contained in *Masonic Hall*, 699 F.2d at 631-632.

[29] See St. Francis I. 265 NLRB at 1029.

employees generally exhibit the same internal characteristics and relationship to other groups of employees, in one health care facility as do like groups of employees at other facilities. To put the matter another way, the various health care facilities we have examined over the years have looked very much the same as other facilities of the same type: large acute care hospitals, small acute care hospitals, and nursing homes.[30]

To give a more specific example, we have observed that registered nurses perform essentially the same duties at all large acute care hospitals, regardless of which large hospital is involved. Differences are insignificant. For example, despite the emphasis by counsel in the oral argument in the recent *St. Vincent* case (19-RC-11496) on the fact that, in that case, not all RNs were in a single nursing department, we note that the precise same situation prevailed in *Mercy Hospitals of Sacramento*, supra, the first lead case involving registered nurses after the 1974 amendments.[31] Similarly, it has been our experience that RNs from hospital to hospital receive more or less the same training, uniformly administer drugs and to some extent oversee the work of aides, work at shifts throughout the day and night and on weekends, etc. Despite these similarities, which we are certain are apparent to any labor law practitioner or other knowledgeable person

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[30] Beyond these types of facilities we are not yet able to generalize and so do not now propose to engage in rulemaking.

[31] 217 NLRB at 768. The Board in the early *Mercy* case permitted the 27 RNs working in departments other than nursing to vote under challenge.

in the health care field, the Board has undertaken to elicit extensive evidence on RNs' duties at each facility sought to be organized, in order to "adjudicate" the appropriate unit in each case. This has come at a tremendous cost to the hospitals, to unions, and to the Board itself, which must furnish hearing officers, court reporters, and lawyers to help the Members decide the cases, based on the heretofore enunciated generalized "doctrines." To the extent one record is different from another, it would appear that is largely the result of counsels' skill or determination in seeking to demonstrate "interchange," "contacts," and the like, mirroring the requirements that have been set forth by the Board in its latest "lead" case. Registered nurses can be expected to communicate with pharmacists about medications, and with maintenance employees about airconditioning systems, regardless of the facility. Especially in light of the fact that, after 13 years, we are no further along in achieving consensus over doctrine than we were in 1974, and since in any event we are convinced that laborious, costly, case-by-case recordmaking and adjudication in this remarkably uniform field has proved to be an unproductive expenditure of the parties' and the taxpayers' funds, we have decided to engage in rulemaking. The Board is of the opinion that rulemaking, though perhaps time consuming at the outset, will be a valuable long-term investment, paying dividends in the form of predictability, efficiency, and more enlightened determinations as to viable appropriate units, leading ultimately to better judicial and public acceptance.

IV. Power To Engage in Rulemaking

Section 6 of the National Labor Relations Act expressly gives the Board power to make substantive rules:

> The Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by the Administrative Procedure Act, such rules and regulations as may be necessary to carry out the provisions of this Act.

This is the standard grant of general rulemaking authority given to Federal agencies. The function of such a grant of legislative rulemaking authority is to permit an administrative agency to fill in the interstices of the Act it administers through the quasi-legislative promulgation of rules to be applied in the future, with the choice between proceeding by general rule or by individual, ad hoc litigation "one that lies primarily in the informed discretion of the administrative agency."[32]

Both sections 9(b) and 9(c)(1) on their face appear to give the Board discretion to make unit determinations. It has been argued that the language of section 9(b) requires a separate determination "in each case," and thus that rulemaking as to units is statutorily prohibited. We do not agree. The adaptability of rulemaking proceedings to unit determinations was considered by Kenneth Culp

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[32] *SEC v. Chenery Corp.*, 332 U.S. 194, 203 (1947); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294 (1974); *NLRB v. Children's Baptist Home*, 576 F.2d 256, 260 (9th Cir. 1978); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d at 414.

Davis, perhaps the leading authority on administrative law, who concluded:

> The Labor Management Relations Act provides: "The Board shall decide in each case whether . . . the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof . . . " Do the words "in each case" mean that the Board is prohibited from classifying problems, from developing rules or principles, or from relying on precedent cases which establish narrow or broad propositions? The answer has to be clearly no; the Board may decide "in each case" with the help of such classifications, rules, principles, and precedents as it finds useful. The mandate to decide "in each case" does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of deciding "in each case" are classifications, rules, principles, and precedents. Sensible men could not refuse, to use such instruments and a sensible Congress would not expect them to. [Davis, *Administrative Law Text* 145 (3d ed. 1972.)]

The Supreme Court urged the Board to use it rulemaking powers in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969). As Justice Douglas there stated:

> The rule-making procedure performs important functions. It gives notice to an entire segment of society of those controls or regimentation that are forthcoming. It gives an opportunity for persons affected to be heard. . . . Agencies discover that they are not always repositories of ultimate wisdom; they learn from the suggestions of outsiders and often benefit from that advice. . . . This is a healthy process

> that helps make a society viable. The multiplication of agencies and their growing power makes them more and more remote from the people affected by what they do and make more likely the arbitrary exercise of their powers. Public airing of problems through rule-making makes the bureaucracy more responsive to public needs and is an important brake on the growth of absolutism in the regime that now governs all of us. . . . Rule making is no cure-all; but it does force important issues into full public display and in that sense makes for more responsible administrative action. [Id. at 777-779].

Moreover, Congress in 1978 considered, though it failed to pass, legislation that would have required the Board to embrace rulemaking in several areas, including an elaboration of appropriate bargaining units. The Senate committee, in endorsing S. 2467, went so far as to state that "there is no labor relations issue on which there has been such a strong consensus of scholarly opinion as on the proposition that the Board should make greater use of its rulemaking authority under section 6 of the Act."[33]

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[33] As reported in BNA Special Supplement, DLR, p. 7 (Feb. 6, 1978). Among the many scholars referred to were Peck. *The Atrophied Rule Making Powers of the NLRB*, 70 Yale L.J. 729 (1961); Peck, *A Critique of the National Labor Relations Board's Performance in Policy Formation: Adjudication and Rule Making*, 117 U. Pa. L. Rev. 254 (1968); Shapiro, *The Choice of Rulemaking or Adjudication in the Development of Administrative Policy*, 78 Harv. L. Rev. 921 (1965); Bernstein, *The NLRB's Adjudication-Rulemaking Dilemma Under the Administrative Procedure Act*, 79

(Continued on following page)

Thereafter, the Seventh Circuit, tired of a case-by-case analysis (on a charge nurse-supervisory issue), stated: "while the Board is entitled to some judicial deference in interpreting its organic statute as well as in finding facts, it would be entitled to even more if it had awakened its dormant rulemaking powers for the purpose of particularizing the application * * * to the medical field." *Hillview Health Care Center*, 705 F.2d 1461, 1466 (7th Cir. 1983).

Recent observers of the Board have been similarily supportive.[34] In one recent article, Professor Charles Morris, editor in chief of *The Developing Labor Law*, suggests that "Substantive rulemaking pursuant to the Administrative Procedure Act (APA) and Section 6 of the NLRA is probably the most important thing the Board can do to effectuate its process, economize its time, and advise the people who need to know – most of whom are not lawyers – what the law requires."[35] Morris urges rulemaking with particular reference to collective-bargaining units in the health care industry.[36] As Morris

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Yale L.J. 571 (1970); Kahn, *The NLRB and Higher Education: The Failure of Policymaking through Adjudication*, 21 U.C.L.A. L. Rev. 63 at 167-175 (1973); Silverman, *The Case for the National Labor Relations Board's Use of Rulemaking in Asserting Jurisdiction*, 25 Labor L.J. 607 (1974); and Davis, *Administrative Law Treatise* section 6.17 (1970 Supp.).

[34] Estreicher, supra at fn. 20; Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 105 (1981).

[35] Morris, *The NLRB in the Dog House – Can an Old Board Learn New Tricks?*, 24 San Diego L.R. 9 (1987), p. 27.

[36] Id. at 41. fn. 149.

suggests, "The wheel need not be reinvented in every case."[37]

In deciding to engage in rulemaking with respect to appropriate bargaining units in the health care industry, it is the Board's desire to substitute for hithertofore unsuccessful doctrines, and lengthy and costly litigation by the parties to each case who seek primarily to advance their own interests in that case, informed rulemaking. In the course of that process, the Board seeks to obtain that empirical evidence that is one of the chief reasons for engaging in rulemaking,[38] and that was alluded to by the Second Circuit in *Masonic Hall*, 699 F.2d at fn.26.

Depending on the numbers of institutions or persons who desire to give oral testimony, it is the Board's intention to conduct a group of hearings, at which knowledgeable persons can give testimony as to how bargaining in the various units at different types of health care institutions has worked. The Board wants to learn how various bargaining units affect legitimate concerns of both unions and health care employers. For example, when registered nurses have been grouped with other professionals, have their interests been properly represented? Has the bargaining, when it has occurred in all-professional groups, nonetheless proceeded on the basis of each separate profession? Have wage rates been negotiated separately despite the all-professional units? When they have existed, have separate professional groupings resulted in

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[37] Id. at 34.

[38] Morris, supra. at 29, 31. See also Subrin, supra at 108-109, 111.

interruption in the delivery of health care? Wage whipsawing? Jurisdictional disputes? These are merely examples of the types of questions that should be addressed by anyone testifying for or against separate units, such as registered nurses, business office clericals, technicals, maintenance employees, etc. The Board is not seeking at the oral hearings the "opinions" and further legal arguments of counsel, which may be submitted as comments, but, rather, actual, empirical, practical evidence offered by industry and union representatives who have themselves participated in or observed bargaining in the health care industry in various configurations. The Board also desires evidence from witnesses with direct knowledge about any recent changes in the delivery of health care, such as cost containment, allegedly greater integration of function between categories of health care employees, and changes in function of specific classifications of health care employees, including greater or lesser degrees of specialization, that may have an impact on the question of appropriate units.

We trust that after receiving and studying such empirical evidence, we will be better able to make an informed judgment as to what units should be found appropriate in the health care industry, because they reflect true community/diversity of interests and do not promote but instead minimize the type of proliferation and interruption of care which concerned Congress in passing the 1974 amendments. No small additional advantage, we hope, will be the attainment of a greater measure of judicial and public deference to what will be our better informed judgment and expertise, with the

long-run advantage of settling, finally, the difficult question of appropriate bargaining units in the health care industry.

V. Proposed Rulemaking

The proposed rule which follows is a new endeavor for the National Labor Relations Board, but not for labor-management agencies generally. A number of States have engaged in rulemaking with respect to appropriate bargaining units for their own employees.[39] The proposal that petitions be entertained only in the proposed units is patterned after a similar provision in the Florida and Massachusetts rules. We have decided not to make the units only "presumptively" appropriate, because one important advantage of rulemaking is the certainty it offers; moreover, as previously indicated, our experience has been that facilities and employee functions in hospitals and other health care institutions of approximately the same size and type are virtually identical. Though an "extraordinary circumstances" exception has been included, it is anticipated that the exception will be little used and limited to truly extraordinary situations; the exception is to be construed narrowly and is not intended to provide an opportunity (or loophole) for redundant litigation. The preamble is by its terms limited to petitions for initial organization, since historically the Board has required decertification petitions to be filed in the

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[39] See, e.g., *In the Matter of State of Florida*, 2 FPER 111 (June 17, 1976). Also, amendment to the Rules and Regulations of Massachusetts Labor Relations Commission, adopted 3 March 1975.

certified or recognized unit.[40] When institutions are partially organized we assume that petitions for new units will follow the proposed rules, insofar as possible.

There is a provision that the listed units will be the only appropriate units, except that any combination will also be appropriate at the union's option and so long as the requirements of section 9(b)(1) and (3) are met. The union is given the option because the Board will have determined that the dictated number of units do not proliferate, and a petition for one of them will be processed to an election without extensive testimony on that issue; a combination would a fortiori be appropriate, since it would proliferate even less. The reference to section 9(b)(1) is included since the statute requires a self-determination election when professionals are sought to be included with nonprofessionals; a combination of these groups, as with RNs (professionals) and LPNs (technicals) at a nursing home, would have to satisfy the 9(c)(1) requirements through the conduct of a *Sonotone*[41] election. Similarly the reference to section 9(b)(3) is included because the statute prohibits the inclusion of guards in bargaining units with other employees.

The proposed rule divides health care facilities into three separate groups. The Board has tentatively decided, based on its experience, that larger hospitals, with their larger numbers of employees in each category, may warrant one or two additional units. In smaller facilities, it is likely that employees will have more contacts with one

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[40] *Cambell Soup Co.*, 111 NLRB 234 (1955).

[41] *Sonotome Corp.*, 90 NLRB 1236 (1950).

another, may to some extent perform one another's work, and generally may share interests more than groupings in larger hospitals.[42] A slightly lesser degree of specialization seems also probable. Recognizing that perfection is impossible in this area, but also being intent on not litigating the precise boundaries of the "small hospital" in each case,[43] the Board has tentatively determined that acute care[44] hospitals of more than 100 patient beds will be deemed "large"; acute care hospitals of 100 patient beds or fewer will be deemed "small." The Board will be grateful for interested parties' comments about these definitions during the comment period. No definition of nursing homes seems required. The Board leaves to future proceedings rules with regard to other types of health care facilities.

As for the proposed units, the Board gave considerable thought merely to advising the public that it had decided to engage in rulemaking, leaving wide open the substance of any rule. However, we have decided to offer a proposal with more specifics, solely for purposes of focusing the debate. It is our best judgment that having such a proposal on the floor, for debate, will prove more fruitful than merely inviting open-ended commentary. However, the Board wishes to make it abundantly clear that while the proposed units at this point are based on the Board's cumulative experience and observation, the

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[42] *See*, e.g., *Mount Airy Psychiatric Center*, 253 NLRB 1003 (1981); see also 217 NLRB 802 (1975).

[43] Subrin, supra, pp. 106-7.

[44] Sec. 2(14) refers to, inter alia, "hospitals" and "convalescent hospitals."

Board has a completely open mind about which and how many units it will ultimately settle upon. That is the purpose of the comment period and hearings provided for, and the Board will reassess its proposed units before issuing a final rule.

The proposed rule notes that "nothing shall prevent the Board from holding additional hearings concerning the specific job classifications to be included in, or excluded from, each of the above units, and from establishing additional rules, where appropriate, about such matters." That is, after this proceeding, in which the Board will determine the contours of appropriate units, the Board may commence additional rule making proceedings to determine the composition of these units, including the professional or technical status of certain classifications which we have encountered frequently in health care cases. As an example, we are advised that there is currently before one regional office a case[45] in which the petition was filed 10 October 1986; hearing commenced 14 November 1986. As of 20 May 1987, the board had taken testimony covering 24 days of hearing, with more scheduled, covering 5978 transcript pages plus 300 exhibits. At issue is the petitioner's desire for a unit of all service, maintenance, clerical and technical employees with a "community of interest," as opposed to the employer's contention that only an all nonprofessional unit is appropriate. Essentially, the parties differed over the placement of business office clericals, and technicals "without a community of interest," but to some extent 300 classifications were in dispute, some as to

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[45] *Christ Hospital*, 9 – RC – 15019.

whether they were technical or professional, and as to whether they shared interests in common with other, included categories. It has been our observation that classifications in the health care industry are to a large degree standardized, and that future rulemaking to determine what classifications are technical, if that unit is ultimately deemed appropriate, or, alternatively, professional, might further shorten proceedings by eliminating duplicative and in some cases self-evident testimony.

The proposed rule notes that the Board will approve consent agreements providing for elections in accordance with the rule, and that nonconforming agreements will be rejected. Further, the rule will be effective on a prospective basis only, for petitions filed on and after (30 days after publication of the final rule).

VI. Justification For Proposed Units

Initially, we emphasize that, except for information we have gleaned from our decided cases, our proposed rule is not based on empirical evidence concerning health care facilities generally. We anticipate that the testimony and commentary we receive in the course of the rulemaking process will contain a significant amount of the empirical data we need in order to verify or modify our original ideas as to which bargaining units are appropriate.

In formulating our proposed rule, we have, of course, kept firmly in mind Congress's admonition against proliferation of health care bargaining units. However, we also have been mindful of our statutory mandate to make unit

determinations "in order to assure to employees the fullest freedom in exercising the rights guaranteed by [the] Act."[46] In addition, we have deemed it significant that the 1974 amendments were intended to encourage collective bargaining by hospital employees in order to improve wages, working conditions, and morale among those employees, reduce turnover, and improve the quality of hospital care.[47] We thus agree with the Second Circuit Court of Appeals that the legislative history of the amendments "does not direct the courts or the Board to erect obstacles to certification of bargaining units that are broader and higher than Congress was itself willing to enact."[48] Consequently, we have drafted the proposed rule with the intent of affording health care employees the "fullest freedom" to organize, while at the same time attempting to avoid the proliferation of bargaining units in that industry that so concerned Congress. We have sought to accomplish this, not by promulgating an abstract standard, but rather by satisfying ourselves that we have limited the possible units in the various types of establishments to a reasonable, finite number of congenial groups displaying both a community of interests within themselves and a disparity of interests from other groups.

The specific units contained in the proposed rule were included, and other possible units were omitted, for the following reasons:

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[46] Sec. 9(b) of the Act, 29 U.S.C. 159(b).

[47] *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 497-498 (1978); see also *Masonic Hall*, 699 F.2d at 634.

[48] Id. at 635.

A. Large Acute Care Hospitals

1. *Registered Nurses (RNs).* Because of the numerous differences that commonly exist between RNs and other professional employees, we have tentatively determined that, in large hospitals, separate RN units are appropriate for bargaining. Thus, in comparison with most other professionals, RNs usually work three shifts, round the clock, 7 days a week, have constant responsibility for direct patient care, and are subject to common supervision by other nurses.[49] RNs also share similar education, training, experience, and licensing that are not shared by other hospital employees.[50] Although RNs do have contact with certain other professionals, such as pharmacists, social workers, and physical therapists, such contacts tend to be less frequent than the RNs' contacts with one another.[51] Moreover, RNs have a lengthy history of organization, both professionally and for purposes of collective bargaining.[52] Finally, because our experience has shown that RNs comprise the largest group of professional employees at most health care facilities, granting them (but not other individual professions) their own separate unit will not contribute significantly to proliferation of bargaining units.[53]

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[49] See, e.g., *Newton-Wellesley Hospital*, 250 NLRB at 410-411, 413.

[50] Id. at 409, 413.

[51] Id. at 410.

[52] *Mercy Hospitals of Sacramento*, 217 NLRB at 767.

[53] *Newton-Wellesley Hospital*, 250 NLRB at 414-415.

2. *Physicians*. For the purposes of the Act, most physicians employed by hospitals are considered either supervisors, managerial employees, or (in the case of interns and residents) students,[54] and hence do not have statutory organizational rights. Accordingly, we envision very few, if any, petitions for separate physicians' units. However, because of physicians' separate education, training, and skills, and particularly because of their unique position as the ultimate supervisors of patient care, we deem it necessary to provide for the possibility of such units in the event they are requested.

3. *Other professional employees*. Section 9(b)(1) of the Act mandates separate representation for professional employees unless a majority of those employees vote for inclusion in a unit with nonprofessionals.[55] The statute thus requires that professional employees not be combined in bargaining units with nonprofessional employees without the consent of the former.[56] While, therefore, a separate unit consisting of all professional employees unquestionably is an appropriate unit for bargaining, for the reasons set forth above, we have (provisionally) determined that separate registered nurses' units also are appropriate. However, in light of the congressional admonition against proliferation of bargaining units, we have determined at this time not to approve separate units of other individual professional employee classifications. Otherwise, we believe, the door would be

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[54] *Cedars-Sinai Medical Center*, 223 NLRB 251 (1976).

[55] 29 U.S.C. 159(b)(1).

[56] *Sonotone Corp.*, supra.

open to the very fragmentation of bargaining units Congress directed the Board to avoid.

4. *Technical employees*. In our experience, technical employees in hospitals and nursing homes, in comparison with other nonprofessionals, typically have significantly higher levels of skill and training, and are substantially higher paid.[57] Consequently, we have consistently approved separate units of health care technical employees and excluded technicals from units of other nonprofessional employees.[58] Our determinations generally have met with approval from the courts of appeals.[59] Based on our current state of knowledge, we do not discern any reason to depart from our existing practice at this time.

5. *Service, maintenance, and clerical employees (except for Guards)*. Service and maintenance employees generally do routine manual work, are not highly skilled or trained, and are paid less than technical employees; consequently, we normally approve separate service and maintenance units.[60] Such determinations have met with court

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[57] See, e.g., *Southern Maryland Hospital*, 274 NLRB 1470 (1985).

[58] Id. See also *Barnert Memorial Hospital Center*, 217 NLRB 775 (1975); *Newington Children's Hospital*, 217 NLRB 793 (1975).

[59] See, e.g., *Watonwan Memorial Hospital v. NLRB*, 711 F.2d 848 (8th Cir. 1983).

[60] See, e.g., *Newington Children's Hospital*, supra. In that case we observed that "a service and maintenance unit in a service industry is the analogue to the plantwide production and maintenance unit in the industrial sector, and as such is the classic appropriate unit." 217 NLRB at 794.

approval.[61] Our proposed rule, however, adds two groups of employees which labor organizations sometimes seek to represent separately, or which labor organizations have sometimes excluded from broader service and maintenance units: clericals and skilled maintenance employees.

We acknowledge that the Board at one time found separate units of business office clerical employees appropriate in health care facilities.[62] More recently, however, our experience has indicated that clericals often share many terms and conditions of employment with service and maintenance employees, and that the two groups have regular, frequent, and significant contacts on the job.[63] Moreover, many employees in health care institutions, besides business office clericals, are engaged in "recordkeeping," such as ward clericals, technicians, nurses, and even physicians. Further, to the best of our knowledge no labor organization has specialized in the representation of business office clericals. For these reasons, and to avoid the proliferation of bargaining units, we have chosen tentatively to include clericals in service and maintenance units. We emphasize, however, that no final decision has been made, and that if evidence exists suggesting that clericals have a distinct community of interests, and that their separate representation would

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[61] See, e.g., *Masonic Hall*, supra.

[62] See, e.g., *Sisters of St. Joseph of Peace*, 217 NLRB 797 (1975).

[63] See, e.g., *Baker Hospital*, 279 NLRB No. 38 (Apr. 16, 1986).

not have unwanted adverse results, such evidence should be presented at the hearings.

Similarly, although at times the Board has in the past approved separate units of skilled maintenance employees (including stationary engineers),[64] in our proposed rule we have provisionally included such employees in service and maintenance units for several reasons. First, we have found that their skill levels at times do not greatly exceed those of other unit employees.[65] Second, many skilled maintenance employees work throughout hospitals' facilities, and thus frequently come into contact with other unit employees.[66] Third, inclusion of skilled maintenance employees in broader units will help to prevent unit proliferation. By contrast, if we were to approve separate skilled maintenance units, many of which would be quite small both in absolute size and relative to the remaining service and maintenance employees, we might well be faced with requests to grant other small units of specialized employees; were we to grant such requests, we would

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[64] See, e.g., *Allegheny General Hospital*, 239 NLRB 872 (1978), enf. denied 608 F.2d 965 (3d Cir. 1979); *Mercy Hospital Assn.*, 238 NLRB 1018 (1978), enf. denied 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980); *Mary Thompson Hospital*, 241 NLRB 766 (1979), enf. denied 621 F.2d/858 (7th Cir. 1980); *West Suburban Hospital*, 227 NLRB 1351 (1977), enf. denied 570 F.2d 213 (7th Cir. 1978); *St. Vincent's Hospital*, 227 NLRB 544 (1976), enf. denied 567 F.2d 588 (3d Cir. 1977). But see *St. Francis II*, supra, and *Shriners Hospital for Crippled Children*, 217 NLRB 806 (1975), denying separate maintenance units.

[65] *St. Francis II*, 271 NLRB at 954.

[66] Id. *Community Hospital at Glen Cove*, 278 NLRB No. 18 (Jan. 17, 1986).

open the door to unit fragmentation and proliferation.[67] Finally, as a practical matter, when the Board has approved separate maintenance units, its decisions have fared poorly in the courts.[68]

6. *Guards.* Section 9(b)(3) of the Act requires that guards not be included in a unit with other employees,[69] and therefore separate guard units must be provided for. Our experience indicates, however, that in practice extremely few guard units are petitioned for, perhaps because hospitals often do not employ guards directly, but instead obtain guards from security services.

B. Small Hospitals and Nursing Homes

Our proposed rule contains the same units for small hospitals and nursing homes as for large hospitals, except that instead of providing for separate units of physicians

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[67] *Shriners Hospital for Crippled Children*, 217 NLRB at 808. Partly because of the size of the employee groups involved, our tentative decisions to approve separate units for RNs in large acute care hospitals, but not maintenance employee units, are not inconsistent. Maintenance employees usually are few in number, whereas RNs, we have observed, almost always are numerous in absolute terms and typically comprise the majority of professional employees. Maintenance employees are aptly compared to members of other specialized professional or technical groups, such as pharmacists or medical technicians. Although each group is set apart from others to some degree by differing skills, training, etc., under the proposed rule we would not approve separate, specialized units for any such group, but instead would combine them into broader units.

[68] See fn.64, supra.

[69] 29 U.S.C. 159(b)(3).

and RNs, it provides for all-professional units. We have tentatively eliminated the narrower units in favor of broader ones because we think that in smaller facilities there will be found less division of labor and specialization, and thus more functional integration of employees' services, than normally is the case in large hospitals. We also expect that there are far fewer professionals other than physicians and nurses in the smaller facilities (especially in nursing homes), and therefore that separate units of "other professionals" are less likely to be appropriate.

VII. Public Hearings

The Board will hold public hearings concerning appropriate bargaining units in the health care industry. The Board wishes to receive testimony and oral presentations from individuals who have direct knowledge of practices in this industry that may have impact on both the number and types of collective-bargaining units that will be permitted. More details about the type of evidence the Board will consider relevant are set forth in section IV above.

The hearings will be conducted at the following locations on the dates indicated:

(1) *Washington, DC* – The hearing will commence at 9 a.m. on August 17, 1987, in the Board's Hearing Room, Sixth Floor, 1717 Pennsylvania Avenue NW., Washington, DC 20570.

(2) *Chicago, Illinois* – The hearing will commence on August 31, 1987. Persons who wish to attend this hearing should contact either the Office of the Executive Secretary

(see address section) or the Board's Chicago Regional Office, Everett McKinley Dirksen Building, 219 S. Dearborn Street, Chicago, Illinois 60604, telephone number (312) 353-7570, to be notified of the exact time and place of the Chicago hearing.

(3) *San Francisco, California* – The hearing will commence on September 14, 1987. Persons who wish to attend this hearing should contact either the Office of the Executive Secretary (see address section) or the Board's San Francisco Regiona! Office, 901 Market Street, Suite 400, San Francisco, California 94103, telephone number (415) 995-5324, to be notified of the exact time and place of the San Francisco hearing.

Persons wishing to present oral testimony at any one of the specified locations should notify the Office of the Executive Secretary, 1717 Pennsylvania, Avenue NW., Washington, DC 20570, telephone number (202) 254-9430, no later than July 24, 1987, advising it of the location at which the witness wishes to testify. Thereafter, all witnesses should submit to the Executive Secretary at the above address eight copies of either the written text or a summary of their presentations no later than 1 week prior to the commencement of the hearing at which they wish to testify. Copies of these texts and summaries will be placed in the docket (see sec. VIII, infra) and will be available at the Executive Secretary's Office, and also at the hearing location where the witness intends to testify, for examination by interested persons.

Any member of the public may file a written statement (eight copies) in lieu of oral testimony before, during, or after the hearing, provided that such statement is

received by the Board on or before October 30, 1987. Written statements should be addressed to the NLRB's Executive Secretary at the address given in the address section of this preamble, and should refer to Docket No. RM-2.

An administrative law judge will preside over the hearings, which will be informal, legislative-type proceedings at which there are no formal pleadings or adverse parties. In general, oral presentations from individual witnesses will be limited to 20 minutes each, except that the presiding judge may impose a greater or lesser period, at the judge's discretion, if he or she deems it appropriate. Participants may desire to ask questions or crucial issues following a presentation. Such questions may be permitted by the judge, limited to approximately 15 minutes per questioner. Questions must be designed to clarify a presentation and/or elicit information that is within the competence or expertise of the witness; questions that are argumentative or in the nature of a statement will not be permitted. The judge shall have discretion to modify the time for questioning, and shall have further discretion to impose other guidelines for the orderly and efficient conduct of the hearing. This shall include the right to require a single representative to present the views of two or more persons or groups who have the same or similar interests, and to identify such persons or groups with similar interests.

The Board will be represented at the hearings by a member of its staff. The judge and the Board representative shall have the right to question persons making an oral presentation as to their testimony and any other relevant matter.

Comments may be submitted which include data, views, or arguments concerning the proposed rulemaking. These should be submitted (in eight copies) to the Executive Secretary, at the address given in the address section of this preamble, and should refer to Docket No. RM-2. Comments must be submitted by the close of the comment period, which is October 30, 1987.

A verbatim transcript of the hearings, and the written statements and comments, will be available for public inspection during normal working hours at the Office of the Executive Secretary in Washington, DC (see address section of this preamble).

VIII. Docket

The docket is an organized and complete file of all the information submitted to or otherwise considered by the NLRB in the development of this proposed rulemaking. The principal purposes of the docket are: (1) To allow interested parties to identify and locate documents so that they can participate effectively in the rulemaking process and (2) to serve as the record in case of judicial review.

As required by the Regulatory Flexibility Act, it is hereby certified that this rule will not have a significant impact on small business entities.

List of Subjects in 29 CFR Part 103

Administrative practice and procedure, Labor management relations.

For the reasons set forth in the preamble, it is proposed to amend 29 CFR Part 103 as follows:

PART 103 – OTHER RULES

1. The authority citation for 29 CFR Part 103 is revised to read as follows:

Authority: Section 6, National Labor Relations Act, as amended (29 U.S.C. 151, 156), and section 553 of the Administrative Procedure Act (5 U.S.C. 500, 553).

2. Subpart C, consisting of § 103.30, is added to read as follows:

Subpart C – Appropriate Bargaining Units

§ 103.30 Appropriate bargaining units in the health care industry.

(a) With respect to employees of "health care institutions" as defined in section 2(14) of the Act, no petition for initial organization shall be entertained, except under extraordinary circumstances, if the petition seeks certification in a bargaining unit not in substantial accordance with the provisions of this rule. The following shall be the only appropriate units, except that any combination will also be appropriate, as the union's option and so long as the requirements of section 9(b)(1) and (3) are met:

(1) Appropriate units in large, acute care hospitals, which shall be defined as all acute care hospitals having more than 100 patient beds:

(i) all registered nurses.

(ii) All professionals except for registered nurses and physicians.

(iii) All physicians.

(iv) All technical employees.

(v) All service, maintenance and clerical employees except for guards.

(vi) All guards.

(2) Appropriate units in small, acute care hospitals, which shall be defined as all acute care hospitals having 100 patient beds or fewer:

(i) All professional employees.

(ii) All technical employees.

(iii) All service, maintenance and clerical employees except for guards.

(iv) All guards.

(3) Appropriate units in all nursing homes:

(i) All professional employees.

(ii) All technical employees.

(iii) All service, maintenance and clerical employees except for guards.

(iv) All guards.

(4) Appropriate units in all other health care facilities:

The Board for the time being will establish appropriate units in other health care facilities on a case-by-case basis.

(b) Notwithstanding the above, nothing shall prevent the Board from holding additional hearings concerning the specific job classifications to be included in, or excluded from, each of the above units, and from establishing additional rules about such matters. The Board will approve consent agreements providing for elections in accordance with the above rules, and no other agreements will be approved. This rule is to be effective on a prospective basis only, for petitions filed on and after (30 days after publication of the final rule).

Dated, Washington, DC, June 26, 1987.

By direction of the Board.

National Labor Relations Board.

John C. Truesdale,

Executive Secretary.

[FR Doc. 87-14895 Filed 7-1-87; 8:45 am]

BILLING CODE 7545-01-M

NATIONAL LABOR RELATIONS BOARD

29 CFR Part 103

Collective-Bargaining Units in the Health Care Industry

AGENCY: National Labor Relations Board.

ACTION: Second notice of proposed rulemaking.

SUMMARY: This Second Notice of Proposed Rulemaking provides for appropriate bargaining units for various types of facilities in the health care industry. The Board has determined that establishing bargaining units by rulemaking will better effectuate the purposes and policies of the National Labor Relations Act than continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case.

DATE: Comments must be received on or before October 17, 1988.

ADDRESS: Comments should be submitted in eight copies to: Office of the Executive Secretary, 1717 Pennsylvania Avenue NW., Room 701, Washington, DC 20570, Telephone: (202) 254-9430.

FOR FURTHER INFORMATION CONTACT: Curtis A. Wells, Associate Executive Secretary, 1717 Pennsylvania Avenue NW., Room 701, Washington, DC 20570, Telephone: (202) 254-9430.

SUPPLEMENTARY INFORMATION: The following is an outline of the contents of this Notice:

XXIV. Regulatory Text

XXV. Dissenting Opinion

I. Background

In our original Notice of Proposed Rulemaking (NPR), we set forth at considerable length the reasons prompting the Board to embark on rulemaking to establish appropriate bargaining units in the health care field. These reasons are set forth fully at 52 FR 25142-25145, July 2, 1987.

Following the Notice, the Board conducted the three hearings announced in the Notice, as well as a fourth hearing requested by several interested parties and announced at 52 FR 29038. At these hearings, all who wished to testify were given an opportunity to do so, and all who wished to ask questions of the various witnesses were given that opportunity. Summaries (cited below as WS) submitted in advance by most of the prospective witnesses facilitated the questioning process.

The first hearing was held in Washington, DC on August 17 and 18, 1987; 20 witnesses appeared, and 496 pages of testimony were taken.

The second hearing was in Chicago, Illinois on August 31 and September 1, 1987; 27 witnesses appeared, and 521 pages of testimony were taken.

The third hearing was in San Francisco, California on September 14, 15, and 16, 1987; 39 witnesses appeared, and 762 pages of testimony were taken.

The final and longest hearing was back in Washington, DC on October 7, 8, 9, 13, 14, 15, and 16, 1987; 58 witnesses appeared, and 1766 pages of testimony were taken.

The comment period, which was originally to last through October 30, 1987, was thereafter extended three times upon the request of various parties [52 FR 36589, 43919, and 47029]. The evidence received by the Board at the hearings and during the comment period substantially exceeded, in both detail and exhaustiveness, what the Board had expected. The transcript of hearing totals 3545 pages, and the 144 individuals who came in person to testify included employees from virtually every broad classification under consideration: registered nurses, physicians, other professionals, technicals, skilled maintenance employees, service and related employees, and business office clericals. In addition, there were union and management negotiators from around the country; a number of professors of nursing, health care management, and other academic disciplines; hospital administrators; health care associations such as the American Medical Association (AMA); representatives of numerous unions including the American Federation of Labor and Congress of Industrial Organizations (AFL), Service Employees International Union (SEIU), International Brotherhood of Teamsters (IBT), United Food and Commercial Workers International Union (UFCW), International Union of Operating Engineers (IUOE), American Nurses Association (ANA) and several of its state associations, Hospital Employees' Labor Program of Metropolitan Chicago (H.E.L.P.), United Nurses' Association of California (UNAC), Communication Workers of America

(CWA), Union of American Physicians and Dentists (UAPD), New York State Federation of Physicians and Dentists; and representatives of various employer groups such as the League of Voluntary Hospitals and Homes of New York. American Hospital Association (AHA), New Jersey Hospital Association (NJHA), Metropolitan Chicago Healthcare Council, Missouri Hospital Association, Ohio Hospital Association, Affiliated Hospitals of San Francisco, California Association of Hospitals and Health Systems, Associated Hospitals of the East Bay, Hospital Council of Southern California, American Health Care Association, and Hospital Council of Western Pennsylvania.

During the comment period, the Board received written comments from 315 individuals and organizations, representing diverse points of view and offering information to supplement what the Board had learned from the oral testimony. These comments alone totalled approximately 1500 pages.

In addition, following the close of the hearings, lengthy comments in the nature of briefs were submitted by the AHA; the ANA; the Building and Construction Trades Department of the AFL-CIO; the IUOE; and the AFL, on behalf of SEIU; National Union of Hospital and Health Care Employees (NUHHCE); Local 1199, Drug Hospital and Health Care Employees Union, Retail, Wholesale, Department Store Union (Local 1199); Federation of Nurses and Health Care Professionals, American Federation of Teachers (AFT); American Federation of State, County and Municipal Employees (AFSCME); CWA; International Union, United Auto Workers; UFCW; and United Steelworkers of America.

The Board is gratified at, and appreciative of, the interest shown in these proceedings by all segments of the industry, including its employees and their representatives. The Board has spent a great deal of time reviewing the evidence collected and the comments received, and believes it is now far better qualified to resolve the issues raised in the Notice of Proposed Rulemaking.

On July 1, 1988, the Board met in open session to discuss further the issue of appropriate bargaining units in the health care industry. The rules tentatively decided upon in that meeting and proposed below have been derived from our analysis of the empirical evidence and comments received during the rulemaking proceeding. The rules now proposed differ in several important respects from the rules proposed in our original Notice of Proposed Rulemaking. Because this is the Board's first major effort at substantive rulemaking, and because the Board is desirous of giving all interested parties a further opportunity to comment on the proposed rules, including the substantial revisions, we have provided for another period of comment. See, e.g., Note, *The Need for An Additional Notice and Comment Period When Final Rules Differ Substantially From Interim Rules*, 1981 Duke L.J. 377 (1981). This Second NPR contains a lengthy Supplementary Information Sec., addressing the major issues presented and containing numerous citations to the rulemaking record. We wish to emphasize that these citations are merely illustrative of the testimony upon which we relied and are not represented as the entirety of the record. We have carefully studied the complete rulemaking record, including the transcript, the witnesses' statements, the comments and briefs, and the exhibits, and have based

our proposed rules on the entirety of this record, and not solely on the testimony specifically cited.

II. Validity and Desirability of Rulemaking

A. Introduction

The Board's statutory authority to engage in rulemaking is derived from section 6 of the National Labor Relations Act, which expressly gives the Board power to make "such rules and regulations * * * as may be necessary to carry out the provisions of this Act * * * ."

In response to several commentators' concerns (e.g., AHA Br. 48: Comment 289. Ross WS Albanese. Charter Medical) and also to the concern expressed by our dissenting colleague, the fact that the language of section 9(b) requires a separate determination "in each case" does not in our opinion mean that the Board cannot promulgate rules to assist it. (See discussion at 52 FR 25144.) It has long been the Board's practice to formulate "rules" to guide it in representation matters. See e.g., the "contract bar rules," discussed in *Appalachian Shale Products Co.*, 121 NLRB 1160 (1958); the "Excelsior Rule," enunciated in *Excelsior Underwear Inc.*, 156 NLRB 1236 (1966); and the *Peerless Plywood* rule, 107 NLRB 427, 429 (1953). Although these rules were formulated by adjudication rather than APA rulemaking, and a majority of the Supreme Court in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969), upheld the validity of the particular rule (the *Excelsior* rule) as applied to the respondent in that case, the plurality implied, and the two dissents explicitly stated, that the Congressionally-preferred course for such

prospective pronouncements would be APA rulemaking. To our knowledge, no court or academic commentator has ever made the contrary suggestion, that section 9(b) forbids utilization of APA procedures to formulate generally applicable representation case rules. As Kenneth Culp Davis observed with specific reference to the language of section 9(b). "The mandate to decide 'in each case' does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of 'deciding in each case' are classifications, rules, principles, and precedents. Sensible men could not refuse to use such instruments and a sensible Congress would not expect them to." Davis, *Administrative Law Text* 145 (3d ed. 1972).[1]

In the Notice of Proposed Rulemaking, we set forth at length our reasons for embarking on this procedure in the health care industry. Initially, we noted that thirteen years had elapsed since the health care amendments were passed, but none of the Board's previously enunciated doctrinal formulas for determining appropriate health care units had yet met with general judicial acceptance. Moreover, in numerous cases it had proven necessary to engage in lengthy, costly litigation over the appropriate bargaining unit or units. In retrospect, it appeared to the

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[1] See also *Continental Web Press v. NLRB*, 742 F.2d 1087, 1093-94 (7th Cir. 1964), in which Judge Posner suggests that the Board's decision in that case with respect to lithographic units would have been more acceptable had the Board used "its dormant rulemaking powers;" and *NLRB v. Majestic Weaving Co.*, 355 F.2d 854, 859-61 (2d Cir. 1966) (Friendly, J.), cited by the court in *Continental Web Press*.

Board that there had been relative uniformity of workforce configurations and job classifications from facility to facility, and even under adjudication the various Board members had reached virtually identical results from case to case. Hence, it did not appear that what some have termed "sensitive, case-by-case adjudication" was serving any useful purpose. The Board also acknowledged that for years it had been urged to engage in APA rulemaking by numerous scholars and judges. In making the decision to engage in rulemaking, the Board expressed the expectation that this type of proceeding would produce the type of empirical evidence most appropriate for a determination as to which of the requested groups warranted separate bargaining units, while not creating such undesirable results as excessive proliferation, interruption in the delivery of health care services, jurisdictional disputes, wage whipsawing, and the like. A fuller exposition of the Board's initial reasons for undertaking rulemaking can be found at 52 FR 25143-145.[2]

Following its issuance of a Notice of Proposed Rulemaking, the Board permitted the parties to comment

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[2] In the NPR, we observed that a number of states, including Florida and Massachusetts, had engaged in rulemaking to formulate appropriate bargaining units for their own employees. 52 FR 25145, fn. 39. We take official notice that, as of November 1987, of the 22 states with comprehensive collective bargaining legislation for state employees, ten (Alaska, California, Connecticut, Florida, Iowa, Maine, Massachusetts, Michigan, New York and Ohio) set their units by administrative rulemaking, and four (Hawaii, Minnesota, Nebraska, and Wisconsin) designate them by statute. Only eight (Illinois, Montana, New Hampshire, New Jersey, Oregon, Pennsylvania, Rhode Island and Vermont) establish units through case-by-case adjudication.

on this matter, and to present testimony in support of their positions. A significant number of health care providers, including the American Hospital Association, opposed the Board's rulemaking efforts. We have carefully considered all their arguments and the evidence submitted in support thereof.

B. Industry's Position

1. *Dynamics and diversity of health care industry.* One argument advanced by a number of employers in opposition to rulemaking was that the dynamics and diversity of the industry preclude it. Thus, the imposition of diagnostic related groups (DRGs) has required new efforts at cost containment (WS Rhodes [AHA] at 1,4; Comment 108, Bonaventure; Comment 130, St. Vincent's Hosp. Ala; Comment 193, Dolly Vinsant Memorial Hospital; Comment 268, Kane). Inflationary pressures have increased while revenues, particularly for in-patient stays, have either decreased or have been governed by ceilings. (Comment 76, South Suburban Hosp.; AHA Br. 3-4; Comment 81, Jordan Hospital; Comment 146, Kennebec Valley Medical Center.) Severe shortages in certain categories of employees have required hospitals to be flexible, which, it is alleged, is inconsistent with the relative inflexibility of rules (Comment 133, Beth Israel Hosp.).

At the same time, there has developed an increasing diversity in hospitals and the services they provide (King, 4232; Comment 19, Johnson City Medical Center Hosp.). Thus, hospitals of all types and sizes are establishing new types of related health care services on outpatient as well as inpatient bases (AHA Br, 5; Dauner, 3217; Comment 44,

McDonough District Hosp.; Comment 71, St.Mary Hosp.; Comment 76, South Suburban Hosp.; Comment 174, High Plains Baptist Hosp.; etc.). Many hospitals are expanding their markets be developing a number of specialty units, such as arthritis units (AHA Br. 7, citing *Modern Healthcare*, July 31, 1987, p. 42); intensive cardiac care, intensive medical/surgical, and neonatal units (Comment 71, St.Mary's Hosp.); trach units, dialysis units, etc. (Comment 78, Greater Cincinnati Hosp. Council). Another change is that hospitals are using part-time workers in increasing numbers to accommodate rapid fluctuations in inpatient census and reduction in full-time employee schedules (AHA Br.7). One large group of proprietary hospitals, National Medical Enterprises, has extensively analyzed services provided in its hospitals to determine what allegedly professional services could be handled by non-professionals; in some of its facilities, it has implemented the "caregiver" concept to replace traditional job labels, within the limits of the classifications' competency. (Donnelly, 4063-80.) It is alleged that rulemaking is not suited for today's diverse and complex institutions (AHA, King, 4232).

2. *Changing structure*. The industry's witnesses presented evidence that the structure of the industry is changing in that hospitals are becoming parts of larger systems encompassing intermediate care facilities, urgent care centers, nursing homes, surgery centers, clinics, etc. (Rhodes, 9-11; NJHA, 320-324, 325; Dauner, 3194; Comment 66, Holy Cross Health Sys.; Comment 203, Deaconess Hosp.). It is alleged that an inflexible rule will impede the Board's ability to respond quickly to rapid changes in the industry (AHA, pos. st. 2). It is claimed

that, because of the myriad of recent changes, this is an inopportune time to engage in rulemaking, which would be better done after the industry has had time to settle down from the current changes (Robfogel, Chi II 233).

3. *Prospects for litigation*. A number of representatives of the industry contended that rulemaking will not reduce the amount of litigation, partly because it will still be unclear into what category various occupations fall (Rhodes, 14; Stickler, 49; Owley, 4379-80; Comment 213, Mulhall, AtlantiCare Medical Center); there will be continuing litigation over the "special situations" exception (Comment 148, Moeller, Mississippi Hosp. Assn.); and, in general, the industry anticipates more litigation rather than a conservation of agency resources (Stickler, letter dated June 19, 1987, RM 2-10; Comment 289, Ross).

C. *Opposing Position*

1. *Litigation*. Though the vast bulk of industry commentators opposed rulemaking, two did not oppose it. Thus, one hospital agreed with the observation that unit determinations in the industry were confused and hard to follow, deeming rulemaking a "welcome relief." (Comment 5, Kane, Holy Redeemer Health System.) Kaiser also does not oppose rulemaking, having observed protracted litigation elsewhere in the industry. (Comment 313, addendum to Kaiser comment.) One student with prior experience as a department head in several hospitals observed that rulemaking may help reduce costs in the industry, so that parties can spend fewer dollars on legal maneuvering and less time on organizing campaigns, leading to more industrial stability. (Comment 122, Shumlas.)

The unions participating in these proceedings supported the Board's rulemaking efforts. (ANA Br. 192-93; New York State Federation of Physicians and Dentists, 79-80; Health Professionals and Allied Employees of New Jersey (HPAE), 122, 127; Union of American Physicians and Dentists, 3649; SEIU, 5155; IUOE, Br. 106; IBT, Saporta, 5101.) They acknowledged the protracted litigation that had theretofore ensued (e.g., Saporta, 5141-42; HPAE, 122, 24; Minnesota Nurses Assoc., WS Patek; Federation of Nurses and Health Profs, WS Owley & 4379-80), producing lengthy delays and great difficulties in organizing (e.g., Lumpkin, 84-85; Nathan, 79-80; Union of American Physicians and Dentists, 3649). One management-side consultant is reported to have admitted that such delays were often part of management's strategy in contesting health care units:

> At a workshop on unions, Raymond Mickus, president of Raymond F. Mickus & Associates in Bannockburn, Ill., predicted that the NLRB rules will spark much more union activity. . . . Under the rules there will be much, faster elections, he said, adding that employers won't have access to hearings or briefs which used to delay the proceedings * * * . There also will be less costs for the unions because they will not have to spend the "megabucks" associated with the hearing process, he said. (Current Developments, BNA Daily Labor Report, Aug. 6, 1987, p.A-2.)

Shortly thereafter, another health care industry representative is reported to have said something very similar: "Delaying representation elections. The greater the time between the initial union petition and the election the less chance there is that the union will win." (Metzger, vice

president of labor relations for Mount Sinai Medical Center, discussing management's strategy, though not necessarily advocating it himself. Reported in Current Developments, BNA Daily Labor Report. Sept. 29, 1987.)

2. *Diversity*. There is some variation between institutions. No two hospitals are exactly alike, but this is true of all institutions. The relevant question, however, is whether, despite surface differences, there are such similarities that certain institutions may properly be grouped as a class. AHA data from 1986 show that while there are a number of different types of health care providers, the overwhelming majority of private, acute care hospitals are general medical and surgical hospitals. Of the 4,381 registered, private acute care hospitals in the U.S., almost 90% are classified by AHA as general hospitals; less than 9% are classified as psychiatric. Of the general hospitals, 96% are medical and surgical hospitals, while only 2% are pediatric, obstetric, or rehabilitation hospitals. (AFL Exh. 7,8.) Inpatient activity accounts for 84% of hospital revenues, and 88% of inpatient beds are allocated to general medical and surgical care, obstetrics, pediatrics, and intensive care. (AFL Exh. 9,10.) The unions contend that the industry has not shown that such diversity as does exist is reflected in different functions for business office clericals, skilled maintenance employees, unskilled service workers, etc. at the different types of facilities.

The unions concede the presence of cost pressures which have changed the climate in which hospitals must operate today (AFL Br. 134; WS Berliner; Comment 293(i). Feldsine). However, they argue that change is endemic in the health care field, and contend that recent changes are not qualitatively different from changes brought about by

the advent of private health insurance or introduction of Medicare and Medicaid, equally profound and dramatic changes (Kennedy, 5549-50). As reflected in the testimony about particular job classifications. DRGs are an accounting and financing mechanism that has nothing to do with the organization of the hospital labor force, and that has not resulted in employees performing jobs that were traditionally performed by other groups of employees (Kennedy, 5551-53; Berliner, 5628-29). In fact, business office clerical's skills have been upgraded because of increased complexity of their work caused by financial pressures (Berliner, 5600). The unskilled workforce has become even less skilled and more vulnerable to layoffs caused by financial shortfalls (Berliner, 5603-04). Similarly, technical employee ranks have declined in the least skilled technical positions while increasing in the most skilled positions as a result of industry changes (WS Berliner at 11-12; WS Schoen at 14-15). Skilled maintenance employees continue to maintain the physical plant (AFL Br. 132). Neither has the role of RNs changed; they continue to provide direct care to patients and clients as in the past (ANA Br. 163).

3. *Changing Structure*. There was evidence that, at least in California, the trend toward consolidation of ownership and management of hospitals into multi-hospital organizations appears to have ended (AFL Exh. 17 at p.2, from California Assn. of Hospitals and Health Systems Report). Further, corporate mergers and larger organizational changes have not affected relationships between traditional job classifications; rather, the changes are in the corporate officers, locus, and method of corporate decision-making (Federation of Nurses and Health

Profs, WS Owley; Patek, Chi I 48; Twomey, 126-127). In any event, the proposed rule does not purport to address the issue of the appropriateness of a single facility, when an employer owns a number of facilities, which the Board will continue to address through adjudication. *Manor Healthcare Corp.*, 285 NLRB No. 31 (Aug. 6, 1987).

D. Conclusion

1. *Agency discretion*. The choice between deciding an issue through adjudication or APA rulemaking is, in the final analysis, within the informed discretion of an administrative agency. *SEC v. Chenery Corp.*, 332 U.S. 194, 203 (1947); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294 (1974); *NLRB v. Children's Baptist Home*, 576 F.2d 256, 260 (9th Cir. 1978); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404, 414 (9th Cir. 1979). Here, we have carefully reconsidered our initial decision in light of all the evidence adduced at the hearings. After examining all this evidence, we remain convinced that rulemaking for establishing appropriate bargaining units in health care institutions is both fair and desirable. The record of these proceedings has supported and amplified our original reasons, set forth in our first NPR, for engaging in rulemaking.

2. *Past adjudicatory decisions*. Our adjudicatory decisions as to appropriate units in the health care industry, where the facts of each case were painstakingly examined in numerous lengthy and costly representation case proceedings, have been remarkably uniform in results, varying only when the Board changed doctrinal formulations, e.g., from "community" to "disparity" of interests. (NLRB

Exh. 5, revised.) Thus, for example, from 1975 to 1984, despite lengthy adjudicatory proceedings the Board found RN units appropriate in 24 out of 25 published cases;[3] technical units appropriate in 18 out of 18 cases; business office clerical units appropriate in 8 out of 8 cases; etc. Though adjudication led to varying results for skilled maintenance units, that was largely a function of a single Board member, Member Jenkins, reaching different results on different records. Other members were, individually, remarkably uniform, despite alleged differences in the records. E.g., Member and Chairman Fanning found the separate maintenance unit appropriate 29 out of 29 times; Chairman Murphy, 26 out of 26 times. Continuing to determine appropriate units in this way seems unproductive, especially considering the lack of universal judicial approval of any single doctrinal approach. (See NPR, 52 FR 25143.)

3. *Financial constraints.* It cannot be denied that health care institutions are at this time operating under serious financial constraints. However, the evidence fails to disclose that these constraints have significantly changed the manner in which individual employee classifications perform their specialties or relate to one another. For example, the record shows that maintenance employees continue to maintain the physical facilities, and RNs continue to provide direct patient care under state nursing practice acts. If anything, the work of the

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[3] The sole exception was *Mount Airy Psychiatric Center*, 253 NLRB 1003 (1981), involving a psychiatric hospital. In each category, unpublished cases exhibited the same uniformity of result.

business office clericals has been shown to have become more specialized and discrete, due to the increasing complexity of reimbursement arrangements, and also the increasing use of computers and word processing equipment. It is our judgment that the increased predictability which rulemaking will bring to the process of determining bargaining units will, in the long run, be a resource saver and, hence, result in cost savings not only for the Board but also for health care institutions as well as for employee organizations. Money expended on the *procedure* of determining appropriate units is not productively spent, except insofar as it leads to a greater understanding by the Board of realities of the workplace; we believe the understanding of the health care industry we have achieved through this rulemaking proceeding has been greater than it was through adjudication, where each party presented a very narrow view of the evidence in order to achieve victory in that particular case. Lastly, insofar as adjudication enabled employers to delay and in that sense save additional costs that might be associated with unionization, we do not think that is an appropriate factor to be considered by the Board in support of continuing adjudication.

4. *Diversity of institutions.* Just as this proceeding has not shown that new cost constraints have made rulemaking inappropriate, neither do we find that any new diversification of institutions has had this result. Such diversity as exists has not been shown to be sufficiently significant to preclude uniform treatment for purposes of establishing the general contours of appropriate

bargaining units[4] for acute care hospitals in all but truly extraordinary facilities. In fact, one witness, the Vice President of Human Resources, Hospital Council of Western Pennsylvania, testified that, even beyond acute care facilities, "the delivery of health care and the functional integration of services of those providing the care is similar if not nearly idenitical throughout the health care industry." (Cammarata, 4394). That same witness pointed out that this similarity in the way health care is delivered is "indeed mandated by various accreditation agencies throughout the health care field" (WS Cammarata at 3). The evidence discloses that the vast numbers of hospitals still perform acute care; insofar as other diverse facilities have developed, such as ambulatory facilities, freestanding emergency centers, etc., these will be considered *infra*, and in our definition of the types of facilities covered by this rulemaking or, alternatively, excluded. Recognizing the diversity of facilities other than acute care hospitals and nursing homes, as well as our limited experience with them, the original NPR excluded such other facilities from consideration in the rulemaking proceeding. These other health care facilities continue to be excluded from coverage.

5. *Litigation*. As described above, the Board anticipates that rulemaking will ultimately result in less, rather than more, litigation about the boundaries of appropriate units. It is acknowledged that there will still be litigation about the placement of individual job classifications within the broadly defined appropriate units. This was

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[4] See Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 9 (1987), at 105-108.

referred to in our initial NPR (52 NPR 25146), and in the proposed new rule itself (§ 103.30(a)); the Board does not see this as a reason not to engage in rulemaking in order first to establish the larger boundaries of the appropriate units. The Board believes it may well be legally necessary, and in any event is wise, to retain an exception for extraordinary circumstances. However, the Board intends to define that exception narrowly, so that it cannot be used as an excuse for unnecessary litigation and delay. See section XX, The Extraordinary Circumstance Exception, *infra*.

6. *Flexibility*. The Board's engaging in rulemaking has no logical connection with the industry's retention of complete flexibility in responding to the needs of the times. Rulemaking is rather a response to a perception that the industry's workforce is susceptible to rules of general applicability about the contours of bargaining units. Health care providers remain as free as they ever were to respond to external events except, of course, as limited by the constraints of any collective-bargaining obligations that may result from unionization; that, however, is a policy set by Congress, not the Board. If, for some reason we cannot now foresee, employers' flexibility to respond is inhibited, any party could, of course, petition for amendment or repeal of the rules, or the issuance of new rules. Board's Rules and Regulations, § 102.114.

7. *Other considerations*. Our colleague dissents and would not engage in rulemaking. However, were we to continue to decide the appropriateness of units in acute care hospitals solely by adjudication, we would not have the advantage of the great mass of evidence presented to

us in this rulemaking proceeding. Indeed, the production of relevant information is one of the chief advantages of rulemaking over adjudication. In addition, as noted above, adjudication itself has resulted in non-fact-sensitive, virtually uniform results, but at great cost in terms both of time and money. These problems, which we have observed in appropriate unit adjudications in this industry since the 1974 amendments, would not necessarily disappear, even were the Supreme Court to grant certiorari and endorse the "community of interests," "disparity of interests," or some other standard. Lengthy hearings would still be required, and the Supreme Court is unlikely to involve itself in particularized, detailed factual inquiries over various appropriate unit determinations. Finally, it is by no means certain that the Supreme Court would grant certiorari on this issue, having declined to do so in *NLRB v. Mercy Hospital Association*, 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980). On another occasion, the Solicitor General refused to file petitions for certiorari, despite the Board's request that he do so, in *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191 (4th Cir. 1982), and *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982). The court in the most recent relevant case, *IBEW, Local Union No. 474, AFL-CIO v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987), remanded to the Board for further consideration, leaving any petition for certiorari susceptible to the argument that the court's disagreement with the Board's result was in any event not final.

III. Standard To Be Applied in Determining Appropriate Units

The Supreme Court has acknowledged on many occasions since the Act's passage that, under section 9, the

Board possesses broad discretion to determine employee units "appropriate" for the purposes of collective bargaining.[5] Of course, even the Board's discretion is not without limits; if the Board's decision as to appropriate unit "oversteps the law," it must be reversed.[6] Within this limit, however, the Supreme Court has noted that any decision as to appropriate units "involves of necessity a large measure of informed discretion, and the decision of the Board, if not final, is rarely to be disturbed."[7]

It has been observed that, in exercising its discretion to determine appropriate units, the Board must steer a careful course between two undesirable extremes: If the unit is too large, it may be difficult to organize, and when organized, will contain too diversified a constituency which may generate conflicts of interest and dissatisfaction among constituent groups, making it difficult for the union to represent; on the other hand, if the unit is too small, it may be costly for the employer to deal with because of repetitious bargaining and/or frequent strikes, jurisdictional disputes and wage whipsawing, and may even be deleterious for the union by too severely limiting

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[5] *Allied Chemical & Alkali Workers, Local No. 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 171-72 (1971); *NLRB v. Hearst Publications*, 322 U.S. 111, 132-35 (1944); *Pittsburgh Plate Glass Co. v. NLRB*, 313 U.S. 146 (1941); *Phelps Dodge Corp. v. NLRB*, 313 U.S. 177, 199 (1941). Not all administrative agencies engaged in regulating labor-management relations possess such broad unit-making discretion. Morris, *The Developing Labor Law*, Second Edition. 415 at fn. 12.

[6] *Allied Chemical & Alkali Workers, supra*, 404 U.S. at 171-72.

[7] *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947).

its constituency and hence its bargaining strength.[8] The Board's goal is to find a middle-ground position, to allocate power between labor and management by "striking the balance" in the appropriate place, with units that are neither too large nor too small.[9]

As if this task, committed to the Board's discretion, were not already sufficiently difficult, in the health care field there may be, as one court has phrased it, a "joker in the deck."[10] Much has been written, especially by reviewing courts, about the effect of the legislative history of the 1974 health care amendments on the Board's discretion to decide appropriate bargaining units. As the D.C. Circuit recently observed, in passing the 1974 amendments "Congress, in the final analysis, decided against modifying section 9 of the Act;[11] * * * hence, the same statutory standards that had existed before the enactment of the 1974 Amendments with respect to unit determinations and certification procedures remained in the statute, entirely unmodified."[12] Even the D.C. Circuit recognized,

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[8] See Gorman, *Basic Text on Labor Law*, 66-69 (1976); Abodeely *et al.*, *The NLRB and the Appropriate Bargaining Unit* 12-13 (rev. ed. 1981); *NLRB v. Hillview Health Care Center*, 705 F.2d 1461, 1469-70 (7th Cir. 1983).

[9] *NLRB v. Hillview Health Care Center*, 705 F.2d at 1469.

[10] *Id.*

[11] *IBEW, Local Union No. 474, AFL-CIO v. NLRB*, 814 F.2d 897, 899 (D.C. Cir. 1987).

[12] *Id.* at 701. The Supreme Court in *Packard, supra*, declined in that case to look at legislative history regarding whether "foremen" could appropriately constitute a bargaining unit, noting that "we are invited to make a lengthy examination of

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though, that other Courts had disagreed.[13] Two Circuits[14] have required the Board to apply a "disparity of interests" test, based largely on the legislative history, while eight others[15] have made it clear the Board should follow the committee's admonition to give "due consideration * * * to preventing proliferation of bargaining units in the health care industry," though they fail to "dictate the precise weight to be accorded the admonition."[16] We believe that rulemaking renders it unnecessary to resolve this conflict, or pick one doctrinal formulation over the other, since rulemaking eschews doctrinal applications in favor of greatly expanded information gathering, to be followed by unit determinations based on empirical judgments of the type that Congress expected an expert, informed administrative body to make.[17]

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views expressed in Congress while this and later legislation was pending to show that exclusion of foreman was intended. There is, however, no ambiguity in this Act to be clarified by resort to legislative history * * * ." *Id.* 330 U.S. at 492.

[13] 814 F.2d at 704.

[14] The Ninth and Tenth. See discussion by concurring Judge Buckley in *IBEW Local Union 474 v. NLRB*, 814 F.2d at 717.

[15] The Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, and Eleventh. See cases cited *id.* at 703-06.

[16] *Id.* at 717.

[17] See, e.g., Estreicher, *Policy Oscillation at the Labor Board: A Plea for Rulemaking*, in proceedings of NYU Annual National Conference on Labor (1964), reprinted in 37 Ad. L. Rev. 163, 172 (1985).

Under adjudication the Board has typically stated it was applying either the "community of interests" or "disparity of interests" standard to the facts of the particular case, as indicated reaching virtually the same result in every case, depending on which doctrine was being applied (NLRB Exh. 5, revised). Under the "community of interests" test, the Board has found five or six units appropriate (not including a statutorily-required separate unit of guards, seldom if ever sought, and a separate unit of physicians, sought in only one published decision since 1974[18]): RNs, other professionals, technicals, service and maintenance, and business office clericals. In addition, some individual Board members have consistently found skilled maintenance units appropriate; others consistently found them inappropriate. (NLRB Exhibit 5, revised.) Under the "disparity of interests" test, the Board has uniformly found three units appropriate, aside from the two seldom-sought units mentioned above: All professional employees, including RNs; technical employees; and service and maintenance employees, including business office clericals.

Though it had consistently reached different results under the two tests, the Board in *St. Vincent Hospital and Health Center,* 285 NLRB No. 64 (Aug. 19, 1987), minimized the conceptual difference between them. Both, the Board stated, looked at the same factors:

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[18] *Ohio Valley Hospital Assn.*, 230 NLRB 604 (1977). See also *Montefiore Hospital & Medical Center,* 235 NLRB 241 (1978), where a separate unit of physicians and dentists was found appropriate, but largely because there were no other professionals employed at the employer's health center, which was deemed to constitute a separate appropriate location.

> * * * the "disparity-of-interests" standard to a significant extent embodies the "community-of-interests" approach. That is, even under the disparity approach, the Board judges the appropriateness of the unit sought in terms of, traditional community-of-interests criteria: employees' wages, hours, and working conditions; qualifications, training, and skills; frequency of contacts and extent of interchange with each other; frequency of transfers into and out of the unit sought; common supervision; degree of functional integration; collective-bargaining history; and area bargaining patterns and practices. Under the "disparity-of-interests" standard – as under the "community-of-interest" approach – the Board looks at the above factors as they are shared by employees in the unit petitioned for, and as they tend to set those employees apart from other employees. Where the "disparity-of-interests" formulation differs from the "community-of-interests" standard, according to the Board's *St. Francis II* decision, is in the significance afforded the above factors. Because of Congress admonition to avoid unit fragmentation, the "disparity-of-interests" test requires more in the way of "disparities" or differences between the employees requested and those in an overall unit to grant a separate unit in the health care industry than would be required under a "community-of-interests" formulation. (Slip op. at 10-11, footnotes deleted.)

It is difficult to weigh or quantify the requirement of "more" as it applies to separate, different interests, i.e., how much would be enough more to satisfy the "disparities" test? Regardless, as we observed in the NPR, "these tests over the past decade or so have developed a 'life of their own,' and have been taken to refer to more or

fewer units, respectively * * * ." (52 FR 25143.) As the Board stated in *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980), various courts' "disagreement with our approach may be largely semantic." And, as the Second Circuit said in *Masonic Hall v. NLRB*, 699 F.2d 626, 637 (1983), a court sometimes enforces the Board's decision if it "can infer from the Board's result that it has taken the nonproliferation policy into account." The court suggested that perhaps courts "focus * * * on what the Board did as much on what it said." *Id.* As noted in the NPR (52 FR at 25143), and in our discussion above, our decision to determine units by rulemaking reflected a desire to replace earlier doctrinal applications with formulations of units based on the facts, or realities, of the workplace, as learned from evidence presented to the Board by interested parties during the rulemaking proceedings.

Under rulemaking as under adjudication, we intend at all times to be mindful of avoiding undue proliferation, not only because this desire was expressed in the legislative history, but also because it accords with our own view of what is appropriate in the health care industry. It would be most undesirable to create or permit a large-scale splintering of the workforce into the numerous trades, technical disciplines, and professions typically found in health care institutions.[19] To give each such

[19] As Abodeely notes, "the health care industry was believed to be particularly vulnerable to the formation of a multiplicity of bargaining units. From the doctors in the top echelon to pot washers on the bottom, the labor force of a large health care facility is composed of a highly stratified, complex myriad of occupational classifications." This was, Abodeely

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grouping a separate voice for organizing and negotiating would create a never-ending round of bargaining sessions and individualized demands not conducive to stability, industrial peace, or the smooth delivery of services to the public. We have entered the rulemaking endeavor with an intention to create a reasonable number of units that will realistically reflect pronounced natural groupings to be found in health care facilities: groupings that will not be so large that organizing them is exceedingly difficult, and representing them even harder because of inherent conflicts of interest within the groups; but large enough that unnecessary, repetitious rounds of bargaining are avoided along with such undesirable results as frequent strikes, wage whipsawing, and jurisdictional disputes. We have not begun with a preordained number, but at the end of our examination will consider whether the numbers of units found appropriate are, in fact, too numerous, See section XXI, Proliferation, *infra*. In any event, there will be no units found appropriate besides those permitted in the final rule.

Although under rulemaking we shall attempt to avoid the doctrinal formulations utilized under adjudication, many of the factors we consider will be similar. Thus, among the factors to be considered will be uniqueness of function; training, education and licensing; wages, hours and working conditions; supervision; employee interaction; and factors relating to collective

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states, the purpose behind the proliferation language referred to in the legislative history. Abodeely, *supra*, at 245. See also *NLRB v. Hillview Health Care Center*, 765 F.2d at 1470.

bargaining, such as bargaining history, matters of special concern, etc. Location and scope of the job market may be relevant: i.e., whether the classification is part of a job market external to the facility or even to health care, or rather shares a job market with others in the facility or, perhaps, in the areawide health care community; job market is a factor not extensively considered under adjudication, probably because evidence regarding it is not likely to be introduced during the litigation of a particular case. In addition to these factors, should the evidence reveal the possibility of a separate unit, we shall examine the likelihood that such a separate unit would result in interruption in the delivery of health care, wage whipsawing, or jurisdictional disputes, matters with which Congress expressed concern during the deliberations that preceded the 1974 amendments. (See, e.g., 52 FR 25145; *St. Francis Hospital (St. Francis I)*, 265 NLRB 1025, 1027, 1035 (1982) (dissent, Chairman Van de Water); but cf. *Manor Healthcare Corp.*, 285 NLRB No. 1, n.7 (Aug. 6, 1987).)[20] The

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[20] Senator Taft, in opening the Congressional debate on the health care amendments, said: "The issue of proliferation of bargaining units in health care institutions has also greatly concerned me. Hospitals and other types of health care institutions are particularly vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients. If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care. . . . I believe this is a sound approach and a constructive compromise as the Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in

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emphasis, during our rulemaking deliberations, has been and will be on the empirical – what, according to the mass of evidence presented, is warranted and will facilitate collective bargaining without jeopardizing the public interest – as opposed to prior, more doctrinal, more conceptually oriented, determinations. We are confident we are now a better informed administrative body in exercising the substantial discretion which we possess in the area of unit determinations.

IV. Two Units: All Professionals/All Non-Professionals

Some members of the hospital industry have argued to us that if the Board engages in rulemaking, it should find only two units appropriate – all professional and all non-professional employees (in addition to guards). Upon consideration of the record, we determine that the evidence does not warrant limiting the number of units to two broad units.

A. Generally; History of the 1974 Amendments

While the industry generally supports two broad units of employees, the support is not universal. Some employers suggest other configurations including a wall-to-wall unit, a separate doctors' unit, and a separate

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this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented." *Legislative History of the Coverage of Non-Profit Hospitals Under the National Labor Relations Act*, at 113-14.

technical unit. (Comment 1, Lancaster Fairfield Community Hospital; Comment 17, Middletown Regional Hospital; Comment 306, Herrin, attorney for health care associations.) Indeed, one employer felt that several separate units was equitable as each had its own characteristics. (Comment 2, Grays Harbor Community Hosp.) The position of some, in favor of two units, is inconsistent with evidence which shows that until *St. Francis II*, employers seldom requested all-professional or all non-professional units (Friedman, 5057), and that where employers did request broad units for elections they sometimes opposed such units during election campaigns or at the bargaining table (see Registered Nurses, section V). On the other hand, unions fully support more than two broad units for organizing (AFL Br. 112; IUOE Br. 8; Local 1199, 3742; FNHP, 3; UFCW, 4457; NUHHCE, 4778; IBT, 5100; SEIU, 5161). These unions' position is consistent with the evidence presented of organizing history (see section V, Registered Nurses; section IX, Skilled Maintenance; section X, Business Office Clericals; etc.).

Contrary to some employers' claim that the legislative history of the hospital amendments supports a two-unit configuration, the history shows that Congress chose not to amend section 9(b) (assuring employees the fullest freedom in exercising rights guaranteed by the Act) in a way that would enact special representation case rules for the health care industry. Even Senator Taft's proposal, which embodied the proposal advanced by *employer* associations in the health care industry but which died in committee, contained special rules established as presumptively appropriate three non-professional units (technical, clerical, service and maintenance), in addition

to a professional unit and guards, for a total of five. Furthermore, the hospital industry agreed, in a negotiated compromise with organized labor, to abandon its request for special statutory rules limiting the number of hospital units in return for provisions governing strikes. (See Legislative History, *supra*, at 91 (Sen. Cranston); 256 (Sen. Taft); 288 (Rep. Thompson), cited in AFL Br. 18-27.) The arguments of many employers that all professionals interact on the job, and that there are insufficient distinctions between classifications of non-professional employees to warrant their separation into different units, and the unions' argument that the record supports separate associational interests, are dealt with under specific unit categories.

B. *The Record Shows That Multiple Units Do Not Undermine Functional Integration of Work; Do Not Result in an Increase in Proliferation, Strikes, Jurisdictional Disputes, or Wage Whipsawing; and Do Not Substantially Increase Industry Costs*

The industry's concerns with having more than two units are the following:

1. *Changes in the industry.* The industry has failed to support its claim by concrete evidence that the DRG method of government payments to hospitals has resulted in restructuring of hospital workforces away from traditional departments and toward a product-line organization that requires greater integration of employee functions. It is claimed that product line management (where different types of employees work in a service related group, for example cardiology) is used increasingly in hospitals and requires that traditional

lines of employment be crossed to provide appropriate patient care as employees in a department cooperate (Abramovitz, 325; Comment 54, Gepford Hosp.; Comment 192, Chicago Healthcare Human Resources Assn; Comment 108, Resurrection Health Care Corp.). However, the evidence shows that product line management has less to do with actual practice on the wards than it does with financial operations performed in the business office (WS Kennedy at 6-7). There is no more interaction between professionals than under other forms of financial control. New financial requirements have not resulted in changes in interaction among hospital workers. (WS Kennedy at 6-7.) Even in hospitals where RNs and other professionals are subject to dual lines of control (combining authority under own licensure and under team or functional department), RNs continue to report to nursing on clinical issues, and retain traditional responsibility for nursing (Comment 293(i), Feldsine; Thompson, Chi II 107; Kennedy, 5561; Fine, 3146-48). Contrary to the generalized claim (Comment 105, Mass. Hospital Assn.) that multiple units would be divisive since one department might contain employees from several units, specific evidence shows that separate units have not prevented effective use of product line management (Houston, 4031, 4048).

In arguing that hospital workforces have moved away from a traditional structure, the industry relies heavily on the team concept, claiming that its use has resulted in greater integration among employees requiring integration of units (Rhodes, 11-12). However, the team concept dates back many years in this industry

(AFL Exh. 12, 13, 14; AMA, 4348). Hospital representatives relied on the existence of teams in their unsuccessful attempt to defeat the 1974 amendments (ANA Br. 126). The record does not demonstrate a substantial increase in the use of interdisciplinary teams since then (AFL Exh. 15, study by Temkin-Grenner; WS Kennedy at 8-9).

Although the industry argued that the team approach is widespread in the country and gave examples of many types of teams such as discharge planning, and special unit teams like oncology, diabetes, and cardiac rehabilitation (Mixon, Chi II 275; Gallagher, 3543-45; Comment 191, Trinity Lutheran Hosp.), the weight of the evidence shows that utilization of team care is neither widespread among hospitals, nor extensively used within hospitals (Bachus, Chi I 132; Lumpkin, 89-90; Dauner, 3236-40; McCullough, 4819-20; Gilmore, 4910). A study of 60 randomly selected hospitals showed fewer than half used discharge planning teams; a minority of the hospitals had special unit teams such as diabetes, oncology, and cardiac rehabilitation (Attachment to AFL Br. from Supplemental Testimony of L. Kennedy). Some hospitals do not utilize the team concept at all (Gilmore, 4910). Most hospitals with teams have no more than six or seven teams, with two to eight members on a team (Coney, 162; Thompson, Chi II 14-15, 72; Mixon, Chi II 277, 294-296), and a majority of employees do not participate on those teams (Bachus, Chi I 129-132). Specialized hospitals, such as children's hospitals, which may use multi-disciplinary teams to a greater extent, are atypical (AFL Br. 104).

The evidence does not support the industry's claim that participation on teams changes the employee's role. Collaboration among professionals is not new (Ballard,

56). For example, one of the most common teams is discharge planning which historically involves nursing and social work. But the team approach does not alter each licensed professional's responsibilities or scope of practice (Ballard, 56; Willman, 4461; Twomey, 131). For example, use of physicians, assistants and nurse practitioners does not alter physicians, scope of practice. Nor does participation on a team affect an employee's wages, hours of work, emplōyment benefits, qualifications, training, skills, job functions, or history of bargaining (AFL Br. 104-105; Graybill, 4174-75; Houston, 4044-45). Where teams are used, only a small proportion of the professional employees are involved. Contact between the members of the team is limited; each member continues to perform the specialized work of his or her profession. The time spent on a team is limited: team members may perform their work separately and then exchange information; team members are not likely to engage in more than fleeting communication regarding collective bargaining matters. (Thompson, Chi II 107, 109, 118-119, 121; and see section V, Registered Nurses, *infra*.) Recognition by the Joint Commission on Accreditation of Hospitals (JCAH) of the need for collaboration on the interdisciplinary level (AHA Br. 16 citing JCAH sec.) does not itself demonstrate that any change in scope of practice occurs.

There is evidence that various employees interact on hospital committees to evaluate hospital programs, but the evidence failed to demonstrate that the interaction affects the professionals' responsibilities or scope of practice (see, e.g., AHA Position Statement p. 8).

The industry made general, unsupported claims that separate units would interfere with the development or

use of the team approach (Graybill-Subrin colloquy, 4185-86; Donnelly, 4131; Coney, 162). There is no evidence that separate units have resulted in failure of professional integration and cooperation on teams (ANA Br. 139; Bullough, 4651-53). On the contrary, teams were shown to be compatible with presence of RN-only units (ANA Br. 123; Thompson, Chi II 86-87; Houston 4048; Bullough, 4651-52).

The industry's emphasis on teams and product lines focused almost exclusively on professional employees. There was no claim that these teams brought technical employees and unskilled service employees together in a single group. Nor was it claimed that business office clericals were involved in health care teams. (AFL Br. 75.) The evidence shows that interdisciplinary teams do not include skilled maintenance employees (IUOE Br. 92; Mixon, Chi II 275).

The industry contends that the use of multi-skilled employees is widespread and on the increase as hospitals seek cost-cutting measures, address the needs of rural hospitals with limited full time staffing needs and large facilities with changing patient loads, and as employee shortages, aging and declining population lead to fewer workers; further, that adoption of the proposed units will abrogate the ability of facilities to effectively utilize multi-trained employees whose skills cut across unit lines (AHA Br. 8, 9; AHA Br. attachment 3 attaching survey by CAHEA; Rhodes, 11; Houston, 4025-26, 4040-42; Comment 137, McDonough District Hospital; Comment 189, Memorial Health System, Inc.; Comment 193, Dolly Vinsant Memorial Hospital). However, the evidence shows that cross-training *between job groups* was not substantial

and did not result in blurring lines between separate units. There are no examples of any group of professionals being cross trained to perform work of RNs either in organized or unorganized settings (Stickler, 22-25; Twomey, 130-131). The interchange of RN functions is not a viable concept because state licensing statutes preclude cross-training of other health professionals in patient care duties and responsibilities of RNs (Ballard, 56-57; Dumpel, 3277-78; Lipari, 3702-03; Rosen, 4665-67; Comment 293(j), paper on licensure of health care personnel).

The evidence shows that multi-competency programs are overwhelmingly aimed at technical employees. They developed because of a perceived need to provide technicians with a broader range of technician skills (WS Schoen, attaching article by F. Morgan). These programs are mainly confined to acquisition of additional technical skills by employees already holding technical jobs as shown by the operation of the programs referred to in the record. Participants in the Methodist Hospital "Add-A-Comp" program which provides employees with laboratory, respiratory therapy, electrocardiograph, emergency medical technician, and similar skills are already licensed or credentialed and include employees having some of the listed skills (Stickler, 19-21 & Chi I 36). Although the Multi-Competency Technical Program at the University of Alabama provides training in medical office skills, it is basically designed to add basic x-ray skills or extend laboratory skills for technicians who are already licensed (Stickler 19-21, Chi I 36-38). There is no showing that students trained in medical office skills actually perform technical tasks. Furthermore, the mere

existence of the program does not show widespread participation, since the record fails to show there are many students involved (Stickler, Chi I 38-39). Moreover, even if these programs turn out a number of multi-competent graduates, they are generally employed in physicians' offices or outpatient facilities rather than in hospitals (Schoen, 5236 and WS Schoen, attaching article by F. Morgan) and their use therefore has little relevance to units in acute care hospitals.

We conclude from the record evidence that cross-training programs extending beyond the technical workforce are rare. Unskilled service workers cannot be readily trained to become technical employees because they lack the advanced education required and because of state licensure laws (AFL Br. 35-36; IUOE Br. 42, fn 5). Service workers cannot be easily trained for business office clerical jobs because of the specialized skills required in the business office (AFL Br. 57-58). Cross training from service to skilled maintenance or technical positions is virtually unknown (O'Cleireacain, 5467; McKinney, 5481). Business office clericals do not transfer into skilled maintenance positions (IUOE Br. 42). Nor are skilled maintenance employees being cross-trained into other job groups (Stickler, Chi I 9, 35-37). The few examples of individuals having interchange of functions (emergency technician starting IVs, RNs doing work after daytime hours normally performed by respiratory therapist or physical therapist, medical technologist trained to watch the heart monitor while RN is on break – Houston, 4026-27, 4042) are very limited. Evidence does show that separate RN units are compatible with limited interchange of function (ANA Br. 153, citing Houston, 4040).

There is no evidence to support the industry's general claim that cross-training has been inhibited by collective bargaining in separate units (ANA Br. 151; IUOE Br. 45; Stickler 45-49). The suggestion (Comment 142, St. Anthony's Health Corp.) that use of multi-competent workers would be hurt by turf battles between professional groups, separate bargaining unit designations, and existing legal restrictions on practice patterns is speculative and is undercut by finding that most multi-competent workers are within one unit – the technical unit. Any problems raised by legal restrictions such as licensure requirements do not derive from the Board's proposal to allow multiple units. Industry testimony on interchange of functions between professionals and non-professionals (Donnelly, 4073-74; AHA Br. 11) is not relevant because the Act would not permit a unit combining professionals with non-professionals, absent a self-determination election by the professionals.

Countering the claim of increasing integration of health care employees is evidence of increasing fragmentation as a result of greater sophistication of work, decrease in the full time equivalent work force and rise in part-time and temporary jobs, increase in the use of subcontracting, growing gaps between patient care and non-patient care jobs (such as business office clericals), and growing gaps between RNs and other professionals because of the RN shortage (WS Schoen).

2. *Proliferation, strikes, jurisaictional disputes, and wage whipsawing*. There is little if any evidence that multiple units in the health care industry have resulted in any of the problems perceived to arise from proliferation such as strikes, jurisdictional disputes, and wage whipsawing.

First, the record shows that most hospitals that are organized have few units (Robfogel, Chi II 223; Comer, Chi II 329; Cammarata, 4424-4425). Logically, the potential for a number of units does not mean that every hospital will be faced with this number of organizing campaigns. Indeed, a successful organizing effort of one unit in a hospital does not appear to have had a ripple effect on further organization (Gilmore, 4894; Splain, 5252-53; IUOE Br. 69-70). Statistics over the last ten years show little organizing in residual units. Health care workers organize no more frequently in facilities where some workers are already engaging in collective bargaining than in facilities where no employees are represented (WS Splain at 14-17). A vast number of organized hospitals have only one unit (WS Schwartz at Table 1 & 264; Sockell, 4520; Shea, 5163). AFL analysis of all hospital contract renewal notices received by the FMCS from hospitals from 1983 to 1987 shows that 55% of all organized hospitals are party to only one collective-bargaining agreement; almost 80% negotiate no more than two contracts; and almost 90% negotiate no more than three contracts (AFL Exh. 5 p. 1). In an SEIU survey of 200 private hospitals, 74% have 3 or fewer bargaining units (WS Shea, SEIU, Table 2).

Evidence shows that, with the exception of New York State, where pre-1974 practice was to permit each employee group to have its own unit, recog ition of RN-only units has not led to organizing efforts by other professionals (King, Chi II 38: In Ohio there is only one unit in which professionals other than RNs are represented separately; Gilmore, 4894: No hospital represented by Maine State Nurses' Association has another

professional unit in addition to RN unit). Existence of a physicians' unit is rare; some states, like Texas, do not permit physicians to be employees of health care facilities (IUOE Br. 64, 99; see section VI, Physicians, *infra*). There is no evidence that the existence of a separate skilled maintenance unit has led to the organization of other units (IUOE Br. 62-65 and section IX, Skilled Maintenance, *infra*).

Some witnesses' statements that multiple units lead to strikes, jurisdictional disputes, and wage whipsawing were, for the most part, general and speculative, and not supported by examples. See, for example, Graumann, 397, 409; Dauner, 3199; Corbett, 3369; Emanuel, 3503-04; Weinrich, 4254, 4256; Cammarata, 4403, 4405-06. The industry did not submit data with respect to the degree of organization, number of organized units per hospital, or incidence of strikes or sympathy strikes, nor evidence that a particular type of unit has proven to be strike prone (AFL Br. 118-19).

In fact, the evidence submitted by unions shows there is a low incidence of strike activity in the health care industry; the rate is lower than in other industries (IUOE Br. 75; NLRB Exh. 1; AFL Exh. 6). The ANA had a voluntary no-strike policy until 1968 (Shepard, 4931-32). The California Nurses' Association (CNA) offers binding arbitration (WS Absalom at 16). According to available data, only 3.3% of all contract negotiations, including nurse bargaining, resulted in strikes. From 1984-1987, strikes in the health care industry occurred substantially less often than in all other industries (FMCS data reprinted in WS Schoen at 28 and AFL Exh. 6). The minimal level of strike activity is confirmed by studies

done by several health care unions. Since 1938, SEIU has had a strike incidence of 1.4% in over 2700 hospital contracts (WS Shea at 10). Of over 1,000 hospital contracts negotiated since 1975 by the NUHHCE, only 43 involved strikes (Muehlenkamp, 4776). IUOE, which represents almost 300 hospital bargaining units, has had only 25 strikes in its history (IUOE revised Exh. 2).

Industry witnesses who testified about collective bargaining experiences in the industry confirmed the infrequency of strikes (Comer, Chi II 320; Corbett, 3374-75; Henry, 3026, 3062, 3085-86). Indeed, Kaiser specifically stated that its observation that there is a greater likelihood of work stoppages in facilities with multiple units was limited to craft-specific units, not the broader, traditional unit groupings (Comment 311). The industry's claim that the Board should discount the lack of strike activity in professional units because few facilities have multiple units supports our finding that in fact few facilities have multiple units.

One study showed there is generally no correlation between the number of units in a hospital and the frequency of strikes (AFL Br. 118, fn citing FMCS study). Other evidence suggests, however, that the likelihood of strikes decreases as the number of units in a hospital increases (IUOE Exh. 2 revised). Strikes also tend to occur more frequently in units with more employees than in smaller units (AFL Exh. 5). For example, only 16.4% of hospital contracts covered 300 or more employees, yet these units account for 45.5% of all strikes, while 51.52% of all hospital contracts covered 100 or fewer employees, but accounted for only 17.7% of all strikes. The average size of a striking unit in the 1984-87 period was three

times the size of a non-striking unit. (AFL Exh. 5 citing FMCS data.) See also WS Shea at 11-12 with similar variation in size of striking SEIU units. Strikes in broader units have the greatest impact on health care. Strikes in New York City by Local 1199 encompassing many worker classifications including other professionals, technicals, service, and clericals closed down most health care in the city. (Abelow, 229.) Strikes in broader units also draw in groups of employees who, if in their own smaller unit, might have no reason to strike (Dumpel, 3291: Strike over nurse practice issues would have no importance to other groups of employees; Viat, 3466; Shea, 5188: Skilled maintenance employees, technical employees enmeshed in strikes over issues related to other groups of employees).

The evidence shows that sympathy strikes are virtually nonexistent. No-strike clauses in hospital contracts forbid sympathy strikes, and the pattern in the industry is for covered employees to obey their contracts. (Schloop, Chi II 169; Sackman, 3585; Ahmed, 3708-09; Muehlenkamp, 4777.)

We cannot accept the argument that multiple strike notices alone, even absent actual strikes, are disruptive, since the purpose of the notice is to minimize possible disruptive impact by giving hospitals time to prepare for a strike. In any event, there was no showing of widespread frequency of strike notices and no evidence that notices caused disruption in health care delivery. Hospitals have not generally sought common expiration dates, which would be a possible solution to recurring near strikes. (Sackman, 3586; Schmidt, 3625; Willman,

4496; Muehlenkamp, 4771; Henry, 3074-75; Corbett, 3359-60; Weinrich, 4282).

Some hospitals' argument that they do not have the same defensive measures as do employers in other industries, for example, because it is difficult to replace striking professionals, is essentially an argument that hospital employees not be allowed to exercise their statutory right to strike. The record does not show in any event that they engage in strikes frequently.

Industry's general claim (AHA Br. 26-27) that multiple units will inevitably result in jurisdictional disputes is not supported by the record. The record shows a low frequency of jurisdictional disputes in hospitals and no correlation between the occurrence of disputes and the number of units. Jurisdictional issues that have arisen are often resolved on an informal basis without resorting to arbitration (Absalom, 3282-83; Sackman, 3585; Schmidt, 3625; Viat, 3471; IUOE Br. 78-79). There was no record evidence of jurisdictional disputes in hospitals between units of professional employees (Emanuel, 3503-4); such disputes are usually fought and resolved in the public arena (Absalom, 3282). Jurisdictional disputes between non-professional groups are rare, apparently because traditional unit lines separate functional groupings and the unit employees do not view the other units' duties as being within their purview (AFL Br. 124-25). The few disputes specifically referred to by the industry, such as accusations of mistakes on the job, and conflict between duties of RNs and LPNs assigned by the hospital (Krasovec, 413-415; Giblin, 5389-90; Graumann, 396-399, 408), encompassed disagreements that could arise even under all-professional and all non-professional units. The

approval of an overall skilled maintenance unit, *infra*, should help reduce the risk of jurisdictional disputes between different skilled crafts.

The industry failed to support its general contention (Rhodes, 13) that multiple units result in employees' competing for the best settlement, burdening negotiations, and inflating settlements. The record shows that wage whipsawing and leapfrogging rarely, if ever, occur in the hospital industry. This is apparently the result of separate labor markets for RNs, clericals, technicals, skilled maintenance, and doctors (ANA Br. 174; AFL Br. 37-38, 59-60, 86-88, 121-22; IUOE Br. 83 citing record), and the method of setting Medicare and Medicaid rates which limits the pass-through of spiralling wage increases (Friedman, 5044-45). In view of the unorganized nature of the health care industry as a whole, separate unit contracts tend to follow wage patterns set by non-union employers (WS Shea at 13).

3. *Costs*. Some unions question the relevance of costs in determining hospital bargaining units. In view of Congressional concern in the health care amendments with the ability of health care institutions to deliver uninterrupted health services, it is relevant to consider whether multiple units increase costs to health care institutions so as to disrupt the stability of the institutions. However, to the extent the industry's contention regarding costs is an argument that employers cannot afford collective bargaining with their employees, we note that the health care amendments were passed in response to Congress' concern with low wages and poor working conditions in the hospital industry. *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 497 (1978). It was anticipated by Congress that the

amendments might lead to increased union organizing and bargaining which in turn might improve employee wages and working conditions. Costs associated with these anticipated improvements are not relevant to the Board's decision as to appropriate bargaining units.

Some commentators claimed that multiple units would increase costs by increasing expenses for contract negotiations, wage and benefit increases, administration and legal fees, grievances, supervision, and accounting (Comment 62, St. Mary's Hosp.; Comment 153, Sturdy Memorial Hosp.; Comment 140, Park City Hosp.; Comment 130, St. Vincent's Hosp., Birmingham; Comment 224, St. Luke's/Roosevelt; Comment 311, Hosp. Council of Southern Calif.). There was no empirical or specific evidence showing comparative labor costs in hospitals with different numbers of units. For example, one witness stated that facilities in Ohio with three or more units devoted more time and resources to collective bargaining than hospitals with fewer units, but had no specific examples (Weimer, Chi II 7, 65-66, 77-79). Another industry witness testified generally that increased costs were associated with negotiating in multiple units in Pennsylvania, but gave no specifics (Cammarata, Hosp. Council of W. Pa., 4392-4430). In fact, studies have found minimal cost impact, 3%-5%, of labor unions on hospital costs. This rate is low when contrasted with the overall rate of health care cost inflation (WS Schoen at 31). The example relating to the costs for negotiations at a public hospital in Massachusetts with eight bargaining units (Robfogel, Chi II 222-23, 228, where out-of-state as well as local attorneys appeared for each negotiating session) was not shown to be typical.

The industry contends that small hospitals are particularly vulnerable to increased costs and cannot afford the money and staff resources needed for dealing with multiple units. However, we were not provided with empirical data for comparison. We note also that few health care facilities have more than two or three units.

The industry's claim that hospitals generally treat each bargaining unit as a separate cost accounting center, thereby adding to the complexity of operating a hospital, is unsupported in the record (Dauner, 3233-34), and in any event is irrelevant.

One witness claimed that multiple units would limit an employer's ability to secure significant cost reductions in employee benefits available now by marketing large groups of employees to third party providers and that the cost of administering multiple employee benefit plans is higher. No specific examples were cited of increased costs (Cammarata, 4402-03). Moreover, benefits may be negotiated across-the-board even in multiple units (Jacquin, 5366-68).

The claim by some that multiple units will result in limiting opportunities for job advancement and security are not supported by the record; neither is the claim that multiple units hamper affirmative action because departmental seniority and separate bargaining deter hiring and career development. To the contrary, there is record evidence (set forth in Sec. V, Registered Nurses and other sections), that there is limited career movement in hospitals regardless of whether or not the hospital is organized because promotions, layoffs, etc. are done by department and because of the distinct skills and education of the

various groups of employees which restrict interchange and mobility. There is also evidence that in organized facilities, unions have sought career ladders, training, and upgrading, and have not acted to limit movement among workers. (WS Schoen at 15; Supplemental Statement of Schoen.)

Some employers argue that multiple contracts limit their flexibility in job assignments, scheduling, and performance evaluation. This appears to be an argument that the industry does not wish to have to bargain since bargaining limits the employer's flexibility. However, the statute gives employees the right to bargain for more favorable terms of employment, and employers have the opportunity at the bargaining table to seek terms giving them flexibility.

Arguments that multiple contracts will result in confusion for management as to which contract covers which employees (Comment 104, St. Francis Hosp., Hartford), that it would be hard for employees to understand and deal with many units (Comment 51, O'Bleness Memorial Hosp.), and that multiple units work against cohesiveness among smaller groups like business office clericals (Comment 138, Rice Memorial Hosp.) were not supported by specific examples.

Finally, the record demonstrates some countervailing considerations to any increased costs as a result of multiple units. At least some of the administrative costs of unit determinations come from the hospitals' opposition to organizing. In 1981, Congress banned the use of Medicare funds for anti-union consultants on estimates that this activity cost $30 million dollars a year (WS Shea at 15,

citing Medicare Manual). There are presently industry costs for prolonged hearings and appeals in many units, which we are confident rulemaking will substantially reduce. Bargaining in large units may prolong negotiations and increase costs as employees are involved who would otherwise have no interest in certain demands (WS Shea at 15). Employers can face increased costs even if there is only one unit, since there may be separate negotiations for different major employee classifications (Owley, 4375-76) or separate contract provisions (Emanuel, 3499-3501). Costs might be contained by combining separate units for bargaining purposes or having common expiration dates for contracts, but the record shows lack of employer support for such union proposals (See Sec. IV(B)(2), *supra*).

C. *Broad Units Militate Against Health Care Employees, Organizing and Bargaining, Contrary to Congress' Intent*

1. *The impact of broad units on organizing and bargaining is a relevant consideration.* As shown above, Congress passed the health care amendments, in part, to improve conditions for health care industry employees by extending to them the rights of the National Labor Relations Act which permits organizing and collective bargaining. *Masonic Hall v. N.L.R.B., supra,* 699 F.2d at 634. While, as the industry correctly contends, the extent of union organization cannot be controlling in unit determinations, it is a factor, and in view of Congress' concerns, the ability of health care employees to organize and bargain is an important consideration in determining whether more than two units are appropriate in the industry.

2. *Historically, health care workers organize and engage in initial bargaining in occupationally homogeneous units.*The evidence shows that broad units militate against organizing by health care workers (AFL Exh. 4, AHA Report on Union Activity in the Health Care Industry). Although there were examples of broad-based bargaining, particularly in New York City, the record shows that organizing and initial bargaining among health care workers has historically been by occupationally-homogeneous units (AFL Appendix A; WS Shea, Table 1, SEIU Survey; and section V, Registered Nurses; section VI, Physicians; and section VII, Other Professionals). For example, in the AFL survey of all private sector hospitals in which an AFL affiliate has organized one or more units, there were 920 homogeneous non-professional units, and only 104 heterogeneous units (AFL Br. Appendix A). The ANA constituent state nurses' associations represent 363 all-RN bargaining units; only 4 all-professional units were organized before *St. Francis II* (Comment 240, ANA, Stull Affidavit). Evidence prepared by the industry confirmed that occupationally diverse bargaining units are found only in a minority of contracts (AFL Exh. 1, [Hospital Industrial Relations Informational Services, p. 5]).

The industry contends that unions have requested or agreed to all-professional and all non-professional units, have successfully organized and bargained in these units, and that therefore a Board decision to find appropriate only two broad units (plus guards) would not negatively impact on organizing and bargaining. The record shows that most union requests for broad-based units occurred after *St. Francis II*, at a time when the Board would have rejected most occupationally-homogeneous units. Broad

bargaining, where it does occur, appears to develop over time, after individual employee unit concerns are addressed and the bargaining relationship has matured (WS Shea at 8; WS Pastreich; Friedman, 5046). Even then, the record shows that employers may meet separately with one or more subunits on their concerns and that there may be separate contract provisions for different concerns. See *e.g.* section VIII, Technicals; section X, Business Office Clericals. Thus, in New York City, where Local 1199 engages in citywide bargaining with the League of Voluntary Hospitals on behalf of its Professional, Technical, and Clerical Division (professionals other than RNs), Hospital Division (service and maintenance employees) and Drug Division (pharmacists, social workers, therapists), the individual units in these divisions were separately organized and negotiated their first contracts separately; joint bargaining of these divisions developed over twenty years (Olson, 4694-4700, 4706, 4716-19; Ratner, 3710, 3725-33, 3738). Proposals are submitted by each separate division; each classification has at least one representative at the bargaining table; and there are local negotiations for specific issues at some hospitals after the master negotiations (Ratner, 3739, 3742, 3757-59; Olson, 4702; Muehlenkamp, 4782). At Michael Reese Hospital, the service and maintenance unit and the business office clerical unit bargain jointly but have separate committees, contracts, and stewards (WS Gray).

There is no evidence of a trend toward coordinated bargaining (Shea, 5217-18). In New York City, there has been some movement away from the citywide approach of Local 1199; there is pressure to go back to each hospital

after the master agreement to get separate provisions on local issues (Ratner, 3739).

Although some industry commentators now request broad-based units, there are a number of instances in the record in which employers sought, for example, to have RNs in a broad unit with other professionals, and then raised the question of effectiveness of bargaining representation, or appropriateness of unit. See section V, Registered Nurses, *infra*. To the extent that employees represented in different units may wish a number of years later to re-group as a single larger entity for purposes of conducting negotiations, nothing in the rule would interfere.

In sum, the record fails to demonstrate that finding a limited number of occupationally-homogeneous units to be appropriate would inhibit functional integration on the job, increase strikes, jurisdictional disputes, or wage whipsawing, or substantially increase costs to industry or to workers. Rather, we believe that finding only two broad units appropriate would unduly hamper organizing and effective bargaining, and would not carry out Congress' intent in the health care industry.

V. Registered Nurses

A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that RNs constituted a separate appropriate bargaining unit in acute care hospitals having more than 100 beds. 52 FR 25146. Among the reasons assigned were that RNs:

(a) Work around the clock, 7 days a week;

(b) Have constant responsibility for direct patient care;

(c) Are subject to common supervision by other nurses;

(d) Share similar education, training, experience and licensing not shared by other employees;

(e) Have the most contact with other RNs; and

(f) Have a lengthy history of separate organization and bargaining.

Much of the evidence taken at the rulemaking hearings concerned the RN classification. As discussed in more detail *infra*, we have decided not to differentiate between hospitals having more than 100 beds and those having fewer. However, in other respects, after carefully considering the evidence amassed, we have determined that RNs appropriately constitute a separate bargaining unit.

B. *The Record Supports a Finding That RNs Constitute a Separate Appropriate Unit*

1. *Work schedules*. There was some evidence of selected other professionals who, at certain hospitals, might be scheduled to work evening and nighttime shifts (Comment 72, McCarthy; Comment 82, Humana). However, the evidence was overwhelming that only RNs have a professional responsibility which requires them as a group to be on duty 24 hours a day, 7 days a week (Chow, 3107-08; Ballard, 55; Schauer, 3155; Ratner, 3735; Graham,

4841-42). They are the only professionals regularly required to work overtime, including as much as two 8- or 12-hour shifts (Bachus, Chi I 144; Wilson, 5074, 5091).

2. *Responsibilities*. Each professional classification obviously possesses its own singular job function and responsibility. However, whereas other professionals specialize, and have intermittent contact with patients, nurses are unique in that their profession demands continuous interaction with patients (Dumpel, 3277-78; Chow, 3108; Ballard, 55, 57-58, WS at 7; Foley, 446). Nursing practice involves the nursing process by which nurses assess patients, as reflected in the nursing practice acts (Comment 240, ANA, Kalisch; WS Foley at 4; WS Ballard at 9-10). RNs continually monitor all patients to be sure that physicians' orders are being carried out and that treatment procedures are not proving harmful (Ballard, 55-56; Bullough, 4627-30). RNs must be alert for errors made by other professionals; for example, if another professional, e.g. a pharmacist, dispenses medication in an improper dosage, the overall responsibility rests with the RN who, if she administers it, is also responsible (Reierson, 3606-07; Sackman, 3586). The RNs' special responsibility is based on a cluster of knowledge which they possess, as opposed to a single skill (Bullough, 4629-30). One 1982 study by Posavac showed that the "perception of nursing care is the single most crucial aspect in the overall rating of hospitals by patients" (Fine, 3143).

3. *Supervision*. All acute care facilities have an organized department of nursing, and that department is supervised by a nurse (Ballard, 52-53). For this reason, the vast majority of nurses in hospitals are ultimately responsible to the director of nursing (Ballard, 67; Lipari,

3703; Gilmore, 4909-10; Comment 293(b), Jones: 3 RNs out of 99 not in nursing department; Comment 293(g), Soltis: 11 out of 200 not in nursing department). The evidence did indicate that in some instances nurses work in departments other than nursing and are subject to supervision by these other departments, such as ambulatory services, discharge planning, home health care, and anesthesiology (Graybill, 4149; Comment 139, S. Baltimore Hospital). However, even in the few instances where a nurse might be hired into another department and report to someone other than the director of nursing, the director of nursing is still responsible for the delivery of nursing care (Ballard, 67-68; Indelicato, 3680).

Product line management is a system of organization by type of service and in response to the DRG method of payment (Dalstrom, 332; Houston, 4024; Kennedy, 5552). It is argued that, with this type of structure, nurses have more in common with those in their product line than with other RNs with whom they have little contact (Dalstrom, 336-339). Ordinarily however, it results in some RNs' being responsible to a functional manager of a project and to nursing heads for clinical issues (Comment 293(i), Feldsine, at 2-3). Product line management is a financial tool; it does not result in changes in interaction among hospital workers (Kennedy, WS at 6-7). As noted *supra*, nurses overwhelmingly continue to report to nurses (Dalstrom, 335: Only 10% of RNs not members of nursing division, but no showing that not supervised by an RN).

4. *Wages*. The labor market for nurses is distinct from that for other professionals (Gonzalez, 4356). Thus, nurse salaries are low, even within the framework of

hospital compensation (Corbett, 3332, 3335). There is no pressure from outside the hospital industry forcing up wages, as for example is the case with pharmacists (ANA Br. 97). Moreover, the overwhelming percentage of nurses are women, and there is evidence that this has contributed to the separateness of the RN wage structure and the distinctiveness of their concerns (Muehlenkamp, 4779; Saporta, 5114-15). When nurses and employers bargain about wages, they look to wages of RNs at other hospitals, not at wages of other professionals (Patek, Chi I 78-79; Absalom, 3316-18). Finally, RN career ladders are very short in terms of pay, quickly levelling out after relatively brief experience (Rosen, 4671). Hospitals recognize the separate RN market by having nurse recruiters; no similar position exists for other professionals (Ballard, 65; Reierson, 3606-09).

Nurses traditionally conduct wage negotiations from these unique disadvantages despite the demand for their services (ANA Br. 99). In fact an employer may insist on a separate wage scale for RNs in an all-professional unit (Comment 51, Castrop: employer reopened wall-to-wall contract at O'Bleness to increase RN wages only).

5. *Wage whipsawing or leapfrogging*. The record evidence based on actual experience shows that wage leapfrogging has not occurred in the hospital industry (Ratner, Local 1199, 3744; Friedman, Local 1199, 5041, 5045; Absalom, CNA, 3316-3317; Muehlenkamp, NUHHCE, 4775; Twomey, WS at 6, Hosp and Prof Allied Employees of NJ; Schmidt, Oregon Federation of Nurses, AFT, WS at 4; Shea, SEIU, WS at 13-14). The one example offered by the industry as evidence of leapfrogging (involving RNs) occurred 20 years ago in California and

concerned the adjustment of wages for RNs who had been underpaid for a long period of time as compared to other hospital employees (as found by a factfinding panel appointed by the governor). Even this adjustment did not result in any disruption of patient care. Moreover, other professionals did not obtain higher wages or benefits thereafter as a result of the RN unit adjustment (WS Absalom, at 7-8; 3286-87).

The fact that RNs are in a different labor market mitigates against leapfrogging (Shepard, 4959-60). Special considerations such as the nursing shortage, recruitment, and retention are not concerns of other professions and have not been carried over into other units (Absalom, 3316-3318). In addition, there are certain limitations or rigidities in the financing system which preclude the pass-through of spiraling wage increases. A significant limitation is found in the Medicare and Medicaid reimbursement rates. These rates play a prominent role in the economics of hospitals, and are set in a regional area in accordance with the general wage pattern set by the most influential local union and its employers. Thus, there is little incentive for unions to engage in whipsaw strikes and efforts to leapfrog the pattern of wage increases. (Friedman, 5044-45.) Finally, it appears that concern about the potential for leapfrogging could be ameliorated by uniform contract expiration dates. However, the evidence shows that hospitals have declined to accept union proposals to this end. (Henry, 3074-76; Absalom, 3318-19; Sackman, 3586; Willman, 4480-82; Clark, 4685.)

6. *Education, training, experience and licensing.* All professions require specialized education and training

(AHA Br. 15; Mixon, Chi II 274), and are subject to prescribed standards of practice (California Health And Safety Code Sec., cited in AHA Br. 15; Comment 248, Cedars-Sinai Medical Center). However, in addition, nurses must pass state licensing exams, which are uniform throughout the country, after graduating from an accredited nursing school. A candidate who passes the exam is competent to practice throughout the country. (Reierson, 3597.) Nurses are required to follow, inter alia, state nurse practice acts, and no other health care worker may function as a nurse under nurse practice acts (Ballard, 56, 57).

RNs' licensing requirements may actually conflict with the requirements and practices of other professions. For example, as previously indicated, RNs fill out incident reports on mistakes in medication dosages made by other workers (Reierson, 3603; Sackman, 3586). This type of responsibility may result in antagonism between the RNs and other professionals which might impede collective bargaining by the professionals as a group.

Several states mandate continuing education for nurse relicensure. Only social workers and pharmacists are subject to such requirements in more states than RNs. (ANA Br. 48; Ballard, 54; Lumpkin, 87.)

7. *Interaction.* RNs work in close and continuous contact with one another within the same hospital (WS Foley; Owley, 4377-78). Moreover, sometimes RNs at different hospitals have more contact with one another than with the other professionals in their own institutions (Owley, 4378; Schauer, 3156-58). With respect to RNs' interaction with non-nurse professionals, while there is

some contact, it is not regular and recurring. There are a variety of factors which help to explain why interaction among RNs and non-nurse professionals is limited. For one thing, while there was testimony that there is a crossover of duties between RNs and other professionals (Thompson, Chi II 55-58), there was also testimony that licensing and other regulations clearly prevent RNs from doing much of the work of other professionals and other professionals from doing RN work (Lipari, 3702; WS Dumpel & 3279). Moreover, non-nurse professionals generally are located away from patient units where RNs are located. For example, in Local 1199-organized hospitals, most pharmacists are located in self-contained units, usually in the hospitals' basements. (Crisafulli, 3712-14.) Moreover, RNs typically have different working hours (Indelicato, 3681; Ahmed, 3707). As noted by the ANA, the contact RNs may have with respiratory therapists is not material since respiratory therapists consistently have been found to be non-professionals. See for example *Samaritan Health Services*, 238 NLRB 629, 638 (1978); *Barnert Memorial Hospital Center*, 217 NLRB 775, 779 (1975).

The point is made that RNs in many cases have more frequent contact with other professions than those other professions that the Board proposes to place together have among themselves (AHA Br. 20-21, citing *Long Island Hospital*, 256 NLRB 202 (1981), and other Board cases). However, this point militates more against grouping of the different professionals than it does toward grouping the RNs with other professionals.

8. *The team concept*. Much evidence was offered during the proceeding concerning the team concept. See also section IV(B)(1), *supra*. After carefully considering this

evidence and the parties' arguments in connection therewith, we conclude that the fact that some hospitals utilize the team concept does not detract from the separate appropriateness of RN units.

There are two types of teams found in hospitals. The first is the nursing team which consists of RNs, LPNs, and aides. This type of team is found throughout the industry. However, as this team contains only nurses and non-professionals, and the Act provides that professionals are entitled to a separate unit if they choose, the nursing team is not relevant to the issue presented.

The second type is the multidisciplinary team which contains various classifications of professionals and non-professionals and has been utilized in the health care industry since the early 1900's. Employers unsuccessfully relied on the existence of teams in an attempt to defeat the 1974 Amendments. (ANA Br. 126, citing Ohio Hospital Association testimony.) The team concept remains non-persuasive for several reasons. First, the evidence at the hearing established that many hospitals do not even use the team concept (e.g., McCullough 4819; Gilmore 4910). Moreover, except for some specialized hospitals, e.g., children's hospitals (Sokatch 4194, 4199; Gallagher, 3539, 3543-46), those hospitals with teams often have no more than six or seven teams (Thompson, Chi II 14-15; Mixon, Chi II 294-96; Graybill 4172-86; Comment 283, Leavenworth), with two to eight members on a team (Thompson, Chi II 72; Mixon, Chi II 277; Gallagher, 3543-45). Thus, within the limited number of hospitals that use teams, only a minority of nurses and other professionals participate on the teams (Bachus, Chi I 129-132, most teams are on the management level).

Although one comment stated generally that the downsizing of staff has led to more teamwork (Comment 263, Huntsville Mem. Hosp), this was not supported by other specific examples.

While members of teams may have daily interaction and weekly formal meetings (Comment 78, Greater Cincinnati; Comment 288, Graybill, Children's Medical Center, Akron), there was also testimony that the interaction of RNs and other professionals is limited in certain ways. For example, team members only interact with the few other members on their teams. Additionally, other duties of RNs may prevent or limit their actual participation in an assigned team program (Schmidt, 3627, 3635; Bachus, Chi I 129-130; Reierson, 3609-10). More importantly, the fact that the RNs may interact and work with other professionals on teams does not alter the separateness of their identity. The team approach is a process to ensure that the elements of patient care are organized. The evidence was uncontradicted that it does not alter each licensed professional's responsibility for his or her individual scope of practice. (Ballard, 56; Twomey, 131; Wilson, 5095; Bachus, Chi I 129-130.) Nor does participation by some RNs in team care affect wages, hours, benefits, training, skills, or functions of RNs on or off the teams (Graybill, 4174-75; Houston, 4044-45).

Conversely, separate RN units were not shown to have interfered with team care (Gallagher, City of Hope, 3540; Bullough, 4651 and 4653; Houston, Sacred Heart, 4031, 4038, 4048). The industry offered only unsubstantiated speculation that team care would be adversely affected; e.g., one witness testified that the amount of interplay, the exchange that goes on minute-to-minute in

critical situations, could be damaged significantly (4185-86). However, at City of Hope, a specialized cancer hospital with a large number of teams and a separate RN unit, the teams remained able to deliver a very high level and quality of care. (Gallagher, 3540 & 3543; Bullough, 4653. See also Thompson, Chi II 9, 86-87: no evidence that separate RN representation at her Ohio hospital has made nurses less able to function as a team.)

9. *Cross-training and interchange.* Because of licensure limitations, cross-training does not take place between RNs and other employees (Lipari, 3702; Dumpel, WS & 3279). Hospital codes also preclude replacement of RNs by other professionals (Rosen, 4666). It logically follows that the extent of interchange between RNs and other non-nursing professionals is limited not only because of RN licensing limitations but also because of the licensing requirements of other professional employees. There was testimony that RNs will perform functions of other "professionals" when the latter are not available, e.g., moving patients instead of physical therapists, or doing respiratory therapist work at night and on weekends (Comment 78, Greater Cincinnati; Comment 198, Marshalltown Medical Center). With respect to the first example, the performance of non-professional tasks such as transferring patients to wheelchairs is not relevant to interchange between professionals. Similarly, respiratory therapists consistently have been held by the Board to be non-professionals. Finally, other examples of interchange, such as medical technologists' watching the heart monitor while a nurse is on break (Houston, 4041-42, 4026-27), appear to be minimal. It was also stated

that both pharmacists and RNs dispense drugs and medications; however, pharmacists typically formulate medications and advise on proper medications while RNs administer them (Thompson, Chi II 55-58).

10. *History of representation and collective bargaining.* The ANA, representing RNs, stated that the RNs' desire to be organized to protect their interests as well as their patients' interests began nearly 100 years ago, and persisted through the onset of collective bargaining and the original Taft-Hartley exclusion of employees of non-profit hospitals from federal labor law (ANA p. 74; see Comment 240, attachment, Kalisch, Twelve Key Steps in the Process of Professionalization of American Nursing, 1854-1987; Comment 293, ANA, Flanagan). AHA contends that separate bargaining by RNs does not reflect a freely established pattern because, prior to the 1974 amendments, it was to some degree based upon considerations of the then-current law in each state and because collective bargaining primarily existed only in a few isolated parts of the country and thus could not be deemed representative. Moreover, the AHA contends, subsequent to the 1974 amendments such bargaining was established pursuant to the direction of the Board.

Regardless of what might first have provided the impetus, RNs have for many years exhibited a strong desire for separate representation. Even during the period following *St. Francis II*, RNs consistently sought separate RN units but were forced to organize into units with other professionals or face lengthy, costly, and fruitless litigation (Saporta, 5127-28; Splain, 5273-74; Muehlenkamp, 4764-67; Wilson 5069). Although forced to include other professionals, the organizing drives were

strikingly similar to prior nurses-only campaigns. Testimony indicates that the campaigns were led by nurses, issues prompting organization were nurses' issues, and the bargaining was performed by nurses, often with no participation by other hospital professionals. (Gonzalez 4356; Splain, 5293; Lumpkin, 99-100; Patek, Chi I 54-55; Chow, 3108; McCullough, 4811; Gilmore, 4894; Shepard, 4927.) Moreover, comments from a number of hospitals indicated they have not had problems bargaining with separate RN units (Comment 79, Baptist Hospital; Comment 105, Mass. Hosp. Assn: 2 examples; Comment 121, Central Michigan).

The AHA makes the point that the more recent history of collective bargaining shows that all-professional units nonetheless are viable, and the record offers some support for this position. Thus, even some RN-only unit proponents have testified that the interests of all professional groups have been adequately represented in bargaining for an all professional unit.[21] (AHA Br. 24.) However, while bargaining could undoubtedly proceed in any one of a number of configurations, this does not necessarily answer the question whether a separate unit of RNs might not also be appropriate; or better reflect the wishes, needs and interests of RNs, other professionals, and perhaps even health care providers themselves.

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[21] That other professionals have not filed unfair labor practice charges or grievances against unions where nurses predominate, charging breach of duty of fair representation, does not mean other professionals are satisfied with representation. A breach of the duty of fair representation is found only where conduct is arbitrary, discriminatory or in bad faith. *Vaca v. Sipes*, 386 U.S. 171, 190 (1967).

The testimony shows that not only have the RNs desired separate representation (Saporta, 5127-28; Splain, 5273-74; Muehlenkamp, 4764-67; Wilson, 5069), but other professionals do not appear to react favorably to their inclusion with RNs. As noted *supra*, the other professionals often do not participate in the organizing campaigns and are hostile to being included in bargaining units with RNs. As an example, when Capitol Hill Hospital demanded inclusion of other professionals, the other professionals complained, became hostile, and some even requested separation (Gonzalez, 4351-53). In Langlade Memorial Hospital, Wisconsin, other professionals forced into a unit with RNs tried to decertify the union but were outvoted by the RNs (Owley, 4376).

The main concern of the non-nursing professionals is of being overwhelmed by the large number of nurses and not having their concerns given priority. RNs are the largest professional group in any hospital. In fact, RNs constitute approximately 23% of the hospital workforce (WS Schoen, Table 1, citing data from AHA publication and BLS Hospital Wage Survey.) They may outnumber other professionals by a ratio of 4 to 1 or more. (AFL Br. 92; Twomey, 123-125, 128-129; Gafni, 133-135; Thompson, Chi II 58.) The non-nurse professionals are also concerned that RNs could ignore their interests when they conflict with RNs' (Comment 134, American Physical Therapists Assn). A number of non-nursing professionals who testified at the hearings confirmed the lack of interest which RNs exhibited toward their circumstances, and the fact that, despite their different professions, they were able to achieve collective bargaining in all-professional units, excluding RNs and physicians. See section VII, Other

Professionals, *infra*. Evidence showed that even when made part of a unit which wins an election, other professionals sometimes do not participate in negotiations or come to union meetings (Schauer, 3154; Wilson, 5070; Patek, Chi I 54, 55-67 and WS 6-7). Issues discussed during bargaining tend to be those of interest to nurses (Wilson, 5073). Moreover, most grievances at one hospital were from nurses on nurse issues (Bachus, Chi I 122). There is a concern that if forced into units with RNs and RNs do not want representation, other professionals would not have enough votes to obtain representation (Owley 4376-77; Ahmed, 3707-08).

The AHA argues that the size of the RNs' group relative to other professionals should not be a consideration in determining whether to have an all-inclusive unit, and that this is a clear departure from the Board's general unit determination analysis in which the Board routinely has included small ancillary groups in units with one or more large classifications that constitute the bulk of the unit. We acknowledge that units frequently are an amalgam of other special interest categories. See, e.g., *Airco*, 273 NLRB 348 (1984). Nonetheless, the Board routinely also finds appropriate separate groups whose interests have been shown to be sufficiently distinctive. See, e.g., *Pacesetter Corp.*, 241 NLRB 1150 (1979) (separate unit of over-the-road drivers found appropriate); *Newburgh Mfg. Co.*, 151 NLRB 762 (1965) (separate unit of garment cutters found appropriate.)

Some employers argued that the real reason unions want separate RN units is that their constitution and bylaws do not permit them to organize other professionals (Comment 306, Herrin). However there was testimony

that some nurses' associations have amended their by-laws to allow organization and representation of other professionals (Gonzalez, 4362; Sackman, 3578). In addition, there was testimony that some employers' true concern with allowing separate RN units is not unit fragmentation but defeating unions. Several witnesses testified that their employer demanded inclusion of other professionals with nurses when nurses wanted separate representation, but then told the RNs they should not include other professionals who did not have their interests. These same employers told the other professionals that they should vote against the "nurses' " union because they would be a minority and nurses could not adequately represent them, thus contradicting the argument of many employers in this proceeding. (Gonzalez, Capitol Hill Hospital, 4351-53; Gilmore, 4896-97; Absalom, 3315; Saporta, 5134; Sackman, 3580-84; WS Splain at 18-19; Wilson, 5096-97.) Employers have also requested the inclusion of lab technicians with RNs, then challenged their inclusion (Wilson, 5087-89).

In several instances, employers who earlier had insisted on the inclusion of all professionals later opposed bargaining with the RNs and other professionals in a single unit when the nurses' union was selected as bargaining representative of an all-professional unit. For example, after the D.C. Nurses Association won an election in a broader unit demanded by the employer, the employer at negotiations proposed removal of non-RNs from the agreement, saying its earlier position had been based on "tactics." (Gonzalez, Capitol Hill Hospital, 4355; see also Lumpkin, Shands Hospital, 95: hospital asked to amend unit to separate RNs from non-RNs; because of

problems with recruiting and retaining RNs, the employer needed to set innovative scheduling, overtime pay for shifts, premiun pay.)

11. *Collective bargaining interests.* There are a number of issues of unique concern to nurses in collective bargaining (See Comment 240(b), submission of David Martin, RN, ANA senior staff specialist for labor relations, affidavit analyzing 190 RN-only unit contracts representing nearly every such contract negotiated in 1986). While there may be examples of how special concerns of the RNs have been addressed in all-professional units, this does not necessarily demonstrate that RNs and other professionals have large numbers of common interests. Nurses can emphasize these issues in bargaining regardless of the concerns of non-RN professionals because RNs would constitute 80% or more in a typical unit (WS Shea at 22), and often 100% of those willing to participate in bargaining (Gonzalez, 4355-4356).

Moreover, that unions are capable of addressing special concerns of the RNs in all-professional units does not negate the fact that many of these issues are unique to RNs and that separate representation would frequently provide a more efficacious and just means for responding to their concerns. For example, RNs alone have recurring concerns with respect to floating, i.e. being temporarily transferred from one unit to another to cover understaffed units (Schauer, 3115). RNs have bargained for mandatory orientation both in their own unit and before floating to other units (Schauer, 3115; Comment 240(b), Martin affid.: orientation provision found in 83 of 1986 contracts). Some organizations representing nurses have created "Assignment Despite Objection" forms to be used

when nurses are asked to work in a unit or perform a function for which they feel unprepared (Graham, 4827; Shepard, 4929-31). Floating and orientation generally do not concern other hospital professionals since they typically are not required to float to areas where they may be unqualified (Saporta, 5114; Indelicato, 3681). Moreover, other hospital professions are not as concerned with staffing in general because they do not have constant patient care responsibilities like the RNs and because they are not in critically short supply (Gonzalez, 4364; at Capitol Hill, staffing was a major concern for RNs, not at all for other professionals).

The evidence shows that scheduling issues are of much greater concern to RNs than to other non-nursing professionals. RNs are virtually alone in their concerns with respect to mandatory overtime and double or rotating shifts, or evening, night and weekend shifts, all of which are said to increase the likelihood of nurse error. (Bachus, Chi I 144; Lipari, 3697; Korn 4860-61; Chow 3111, Ballard, 62, 75.) There were only isolated examples of non-nurse professionals working late shifts or weekends. Many other professionals, like social workers, work primarily day shifts during the weekdays. (Roth, 3151: no pharmacist, social worker or physical therapist at night, skeleton crew for respiratory therapy; WS Foley at 6-9: social work, physical therapy, doctors, offices are all closed by 6 p.m., some evenings only RNs provide primary care.)

Collective-bargaining agreements have addressed these issues by, e.g., attempting to limit mandatory overtime, rotating shifts, etc. (Comment 240(b), Martin affidavit; Chow 3110-11.) Collective bargaining agreements

covering other professionals do not usually include such provisions (Friedman, 5055; Local 1199 contracts for medical technologists do not prohibit mandatory overtime).

Hospitals have difficulties attracting nurses to work the less desirable evening and night shifts. Ninety-eight percent of contracts in the ANA study provided higher wages on evening and night shifts; 57% offer some form of alternative scheduling designed to attract RNs. (Comment 240(b), Martin affidavit.) Other professionals generally view issue of premium pay and alternative scheduling as less important or irrelevant. This in part is due to the fact that non-nursing professionals usually do not work night shifts and many do not work evening shifts (Patek, Chi I 55: non-RN professionals had grave concerns about bargaining over premium pay for fear that this would mean that they would be required to work shifts they had not worked before. See also WS Lumpkin, supra at 8: re: innovative scheduling for RNs; Gilmore, 4907.)

12. *Education*. Nearly every surveyed contract has provisions for continuing education which is mandated in 15 states (Comment 240(b), Martin affidavit). Continuing education typically presents different issues for nurses, who work around-the-clock schedules and have difficulty attending the courses, which are often given evenings, nights, or weekends. Thus, other professionals typically bargain about continuing education by seeking more money; RNs seek time off to attend as well as tuition. (Lumpkin, 86-88; Foley, 449-450.) This in itself would not justify a separate unit as such concerns could, of course, be accommodated in larger-unit bargaining; however, they are but one of a congery of concerns and

special problems that make nurses a substantial, unique group.

13. *RN bargaining units and strikes.* There is testimony that there have been many strikes by nurses (King, Chi II 41, 46, 28; Whelan, Chi II 59-61, 85; Comment 304: one-third of 20 strikes at Kaiser since 1974 amendments are in RN-only units), and that some of these strikes have lasted for a long time (e.g., Ashtabula Hospital, Ohio, 572 day strike: King, Chi II 28, 59-61). However, according to available FMCS data, only 3.3% of all health care contract negotiations, including nurse bargaining, resulted in strikes. The strike percentage in any given year never exceeded 5.1% and fell below 2% in several years. Moreover, during the 1984-1987 period, strikes in the health care industry occurred far less often than in other industries, 1.5% v. 2.4%. (WS Schoen at 28; AFL-CIO Exh. 6.)

There was testimony that RN strikes are particularly disruptive because RNs constitute the largest group of hospital employees. For example, there was a strike of 6,000 nurses in Minneapolis-St. Paul in 1984 over job security (Patek, MNA, Chi I 51, 63). But there was also testimony that where strikes occurred, the hospitals continued operation (Whelan, Chi II 59-60; Viat, 3471). Moreover, we must also be mindful that in an all-professional unit, RNs, because of their predominance, could generally obtain an affirmative strike vote even if all the other professionals were opposed. Because such a strike would involve all professionals in the hospital, greater disruption of hospital services would result than with a separate RN unit. (ANA Comments 173.) Finally, for 18 years ANA had a no-strike policy (Shepard, 4931-32; Comment

293(k), Flanagan, *Collective Bargaining and the Nursing Profession* at 14-15), and CNA has adopted a standing policy that in the event of an impasse in arbitration, it will offer binding arbitration before resorting to strike action (Absalom, WS at 8-9, 12-13, 15-16 & 3286-98: 1974 strike resolved by FMCS; 1978 shift rotation disagreement resolved by advisory arbitration; 1980 disagreement on nursing shortage resolved by mediation-arbitration).

The AHA argues that the history of the RN-only unit bargaining does not support a conclusion that potential work disruptions are not increased by creation of multiple professional bargaining units, since the overwhelming majority of facilities where RN units exist have no other professional units (AHA Br. 24). However, because in all likelihood the latter phenomenon would continue to exist, this argument is not entitled to great weight.

Some commentators argued that multi-professional units may lead to sympathy strikes (Bennett, 3045; Comment 13, Corkin). However, most no-strike clauses in hospital contracts forbid sympathy work stoppages, and there was evidence it is common for RNs to cross picket lines set up by non-nurse health care workers (Sackman, 3585; Lipari, 3696; Korn, 4889; Roth, 3152-53). If sympathy strikes were a problem, it appears that they could be significantly reduced by mandating common expiration dates for all hospital contracts, a proposition which, the evidence showed, hospitals frequently or even universally have rejected (Absalom, 3318-19: Affiliated Hospitals refused to allow new expiration date to coincide with expiration of other contracts; Clark, 4683-85: no common

expiration dates for initial contracts; Abelow, 249-50; no push from any parties to coincide RN contract expiration with master contract of League of Voluntary Hospitals; Lipari, 3697: employer opposes common expiration dates).

14. *Jurisdictional disputes.* The record does not reveal a single jurisdictional dispute between unions of professional employees (Fine, 3156-3158). Witnesses who asserted that such jurisdictional disputes would arise did not substantiate their claims (Dalstrom, 339; O'Connell, 440; Dauner, 3199; Emanuel, 3503-04; WS Cammarata at 7). In fact, the most typical job duty issues involving jurisdictional lines are between RNs and nonprofessionals, i.e., LPNs and nurses' aides (WS Shea at 14). These types of issues would arise even if the RNs were placed in an all-professional unit.

As was the case with regard to strikes, the AHA argues that an assessment of the impact of multiple professional units on jurisdictional disputes can only exist where there are two or more units represented by labor organizations in a facility, and there are very few such instances (AHA Br. 24). For this same reason, we believe the argument that there is a potential for jurisdictional disputes among professionals where a separate RN unit is given, is speculative. To the extent the record deals with this matter, it shows that any issues regarding the possible overlapping duties of professionals have in the past been fought out in the public arena. For example, attempts by other groups to perform some of the nurses' duties under their scope of practice in California were dealt with by the legislature. (Dumpel, 3278-79.) In any event, as noted *supra*, (see subsection (B)(9) on cross-

training and interchange), interchange of duties between professionals appears minimal.

15. *Nursing shortage.* It is common knowledge, and the record substantiated, that currently there is an unprecedented and severe nursing shortage (Absalom, 3295; Shea, 5235; WS Schoen at 16, citing ANA Report on Hospital Nursing Supply). Some hospitals have delegated some traditional RN functions, not reserved to RNs by law, to employees with no RN training. Additionally, hospitals currently have more seriously ill patients (higher acuity) than historically reported. Less qualified nurses, and fewer nurses, will be forced to attend to more seriously ill patients, leading to a lower level of care and more stress for the remaining RNs who may then opt out of nursing. (ANA Br. 101, and articles cited therein.)

Nurses testified that they view collective bargaining, in their own unit, as the vehicle for improvement in their working conditions and for allowing them a voice in patient care (Ballard, 72; Lumpkin, 85-86). Additionally, hospitals are trying innovative proposals for nurses: opening contracts for them alone, raising wages, setting weekend differentials. Some think that if other professionals are included in units with RNs, problems could arise if such changes are also not implemented for non-nursing professionals. (Wilson, 5071; Saporta, 5116.)

It has been argued that the Board should not give special consideration to a group in temporary crisis or other groups will also make demands for separate units (Comment 65, Milford Hospital). However, while the evidence establishes that the situation is a serious one and appears to be growing more serious with time (ANA Br.

100-101, and articles cited therein), we view this as only one valid factor in determining the appropriateness of a unit limited to RNs. The concern that this will lead other professionals to follow suit is speculative, and insufficient reason to deny RNs, who have already established their unique concerns and a highly separate identity, a separate bargaining unit.

16. *Proliferation of units.* As has been documented elsewhere, the evidence in the record does not support the assumption that the recognition of RN-only units will lead to a demand by other professional groups to organize as separate units. In fact, as previously indicated, the AHA acknowledges in its brief that in the overwhelming majority of facilities where RN units exist, other professionals have not been represented in separate units. (AHA Br. at 24.) SEIU health care organizing director Splain concluded that 10 years of statistics show relatively little organizing in residual hospital units. There are 16 hospitals in Ohio that have a separate RN unit, and only one unit in which professionals other than RNs are represented separately. (King, Chi II 38-39; Shepard 4927.) Health care workers organize no more frequently in facilities where some workers engage in collective bargaining than they do in facilities where no bargaining units have been represented (WS Splain at 14-17). One witness testified that a typical hospital has an RN unit, an LPN unit or technical unit, a service and maintenance unit, and sometimes an operating engineers unit (WS Patek at 4).

C. Conclusion

We have carefully considered the evidence in the hearings as to how a separate RN unit, or, in the

alternative, an all-professional unit including RNs, might fare, based on the realities of hospital operations, organizing, and collective bargaining. We conclude based on this evidence and the arguments advanced that a separate RN unit is appropriate for collective bargaining purposes.[22]

For many years, RNs, who constitute a significant portion of the health care workforce, have demonstrated their commitment both to their careers in the health care industry as well as their patients' well-being. During the time period following *St. Francis II*, it appears that RNs consistently desired separate RN units but were compelled to organize into all-professional units in order to avoid prolonged litigation. However, even when the RNs were forced to include other professionals in their units,

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[22] In making our decision on this issue, we have considered *St. Vincent Hospital and Health Center*, 285 NLRB No. 64 (Aug. 19, 1987), a fairly recent case in which we held in an adjudicatory proceeding that a separate RN unit was inappropriate. In so doing we found, *inter alia*, that all of the employer's professional employees "share common personnel policies and procedures and fringe benefits and have sufficient contacts and interaction to support the finding that the smallest appropriate bargaining unit is one consisting of all of the Employer's professional employees." *Id.*, slip op. at 13. Having now had the opportunity to consider the substantial empirical evidence adduced in this rulemaking proceeding, we have a far better understanding of the RNs' training, functions, interests, and involvement in hospital operations, and of the actual and potential ramifications of each type of unit. For the reasons stated in this section, were we to apply the empirical evidence presented in these hearings, we might well reach a different result in *St. Vincent*.

the organizing drives were quite similar to prior nurses-only campaigns.

Moreover, it is apparent from testimony taken at the hearings that non-nursing professionals did not wish to be included in a unit with RNs. If we ignore the perspective of the smaller, non-nursing professionals group, i.e., the animosity expressed toward their inclusion with RNs as well as their concern that their "voice" will not be heard, then we are disregarding, at least in part, one of our major objectives. As previously indicated, the Board seeks to avoid finding too large a unit appropriate, as this may result in "too diversified a constituency which may generate conflicts of interest and dissatisfaction among fringe groups, making it difficult for the union to represent * * *." See section III, Standard To Be Applied, *supra*. This latter point appears to be a concern of nursing and non-nursing professionals alike, and is one reason we have decided to permit RNs to seek bargaining rights apart from other health care professionals.

There was also testimony that would lead us to believe that some hospital employers' true concern with prohibition of separate RN units was not possible fragmentation but rather defeating organization. This was demonstrated by evidence of, *inter alia*, employer opposition to bargaining with the RNs and other professionals in one unit when an all-professional unit was finally certified, despite these same employers' earlier efforts to require that all professionals be included.

The distinct functions and collective bargaining interests of RNs compel the conclusion that a separate RN unit

is warranted. RNs are a unique group in that their profession demands continuous interaction with patients. Additionally, because of licensure limitations, other professionals may not perform RN work and vice versa. RNs have a separate labor market, and scheduling issues are more of a concern. These factors and others discussed *supra* support a finding that collective bargaining by RNs as a separate unit should be permitted.

The industry has contended that adverse consequences would follow having separate RN units, such as strikes, jurisdictional disputes, and proliferation of units. The testimony proffered at the hearings has satisfactorily alleviated any concern we had over these possibilities.

Finally, we are mindful of the growing problem involving the nursing shortage. While separate representation for the RNs does not provide the complete solution to this problem, we believe that it is an important step toward making the nursing profession a more attractive employment opportunity as the separate concerns of RNs are addressed more directly in a separate RN unit.

VI. Physicians

In our Notice of Proposed Rulemaking, we provided for separate units of physicians in acute care hospitals having more than 100 beds. Although we did not anticipate the formation of many such units, we stated we would permit them because of physicians' separate education, training, and skills, and particularly because of physicians' unique position as the ultimate supervisors of patient care.

As discussed *infra*, we have decided not to differentiate between hospitals having more than 100 beds and those having fewer. However, as with RNs, see section V, *supra*, the evidence produced during this proceeding supported the proposed separate unit of physicians.

Doctors have considerably more training than other professionals, i.e., four years of medical school plus two to six years of post-graduate residence training, working as student residents in hospitals under the tutelage of licensed physicians (WS Cornfield).

Doctors have the singular responsibility of directing all other patient care employees; the JCAH charges doctors with overall responsibility for the quality of professional services (Robinson, 3650-51; WS Todd at 4-5, citing 1987 Accreditation Manual). Malpractice claims are filed against doctors because they are responsible for medical treatment (Robinson, 3652). The AHA contends that all professionals are held responsible for malpractice (AHA Br. 30); while we do not doubt the truth of this assertion in some circumstances, the AHA offered no details.

It is common knowledge that doctors earn substantially more than other professionals. They are frequently salaried, entering into individual employment contracts with hospitals rather than having an overall wage scale applied to them. (Comment 94, Somers; Robinson, 3652; NYS Federation of Physicians' and Dentists' position paper Exh. D.)

Supervision of doctors is limited and is generally done by other doctors (Robinson, 3651; Comment 293, Feldsine). While we recognize that other professionals are also commonly supervised by their peers (Comment 71,

Kowalski, St. Mary's Hospital), as indicated doctors are ultimately responsible for the care given patients.

Doctors, of course, work with other employees, particularly on teams, or committees (Comment 137, McDonough Hospital; Mixon, Chi II 291; Comment 248, appending statement from Spitzer of Cedars-Sinai). However, we are persuaded by the evidence that the team approach does not change the duties of doctors, which are limited by law. Other employees are not permitted to do work within doctors' scope of practice. (Todd, 4348; Comment 269, Todd, AMA.)

Aside from the other factors noted, doctors have particular interest in bargaining about medical education, malpractice insurance, and input into patient care decisions (Robinson, 3655). They have little interest in the issues of special concern to RNs, such as floating, per diem, uniform allowances, overtime, etc. (NYS Federation of Physicians' and Dentists' position paper, Exhs. B, D, E, and F), and are outnumbered by nurses at a ratio of at least 15:1 (Todd, 4324, 4328), and perhaps 20:1 (AHA Br. 28). We are concerned that if doctors were forced to be included in the same unit with nurses and other professionals, doctors' interests would be overwhelmed (Todd, 4324). Florida, after 10 years, removed doctors from an all-professional unit in state facilities because of money considerations (Lumpkin, 100, 111-12). In one wall-to-wall unit including doctors, the hospital wanted raises just for doctors because of recruitment problems; the union opposed this because it would give raises just to one group in the unit (Robinson, 3654-55). A number of employers similarly expressed concerns about putting physicians in units of other professionals (Comment 94,

Somers, attorney to many health care facilities: Comment 304, Kaiser Permanente; Comment 1, Lancaster Fairfield Community Hosp.; Comment 17, Middletown Regional Hosp.; Comment 48, St. Vincent's Medical Center, Bridgeport; Comment 141, Ayres). A wall-to-wall unit at O'Bleness Hospital did not include doctors (AHA Exh. 8D).

While the number of doctors employed in hospitals is small, and the percentage of employed doctors compared to other employees remains about the same, the actual number of employed doctors is increasing (Todd, 4335), and there is some evidence that doctors are organizing at increasing rates (AFL Exh. 4).

We are persuaded that the evidence weighs in favor of a separate unit for physicians, where sought. Thus, to include them with RNs and other professionals seems likely to lead to divisiveness and quite possibly to conflicts of interest. We have found no evidence that to grant doctors a separate unit would lead to repetitious bargaining, frequent strikes, or jurisdictional disputes. We believe the proper balance is struck in favor of a separate unit for all physicians, where requested.

VII. Other Professionals

In our original Notice of Proposed Rulemaking, we tentatively provided for a separate unit of all professional employees, excluding registered nurses and physicians, in acute care facilities having over 100 beds. We noted that section 9(b)(1) of the Act mandated separate representation for professional employees unless a majority of those employees vote for inclusion in a unit with non-

professionals. In view of the provision for separate RNs' and physicians' units, it was and continues to be necessary to provide for a separate unit of professionals excluding these two classifications although, as noted *supra*, we have decided to abandon the proposed 100-bed differentiation.

A number of so-called "other professionals" appeared in person at the hearings to testify. In general, they confirmed the lack of interest which RNs exhibited towards their circumstances, and the fact that, despite their different professions, they were able to achieve collective bargaining in all-professional units, excluding RNs and physicians. (Indelicato, social worker, 3673, 3678; Ahmed, laboratory technologist, 3705-06; Crisafulli, pharmacist, 3711, 3737.) In a comment, physical therapists expressed a preference for their own separate unit, but if placed with other professionals they would prefer that unit did not include RNs (Comment 134). Some fear was expressed that, because of their numbers, RNs (and also technicals) would overwhelm the other professionals if included in the same unit with them (Ratner, 3731-32; WS Cornfield, Table 1).

A number of "other professional" classifications work relatively independently, and have no immediate direct supervision (Ratner, 3735). They generally work the day shift, on weekdays (Indelicato, 3681), though some work on other shifts (see, e.g., Comment 275, Presbyterian Hospital). As a group they have high prestige within the hospital because of their superior education and training (WS Cornfield, Table 6).

Despite the desire expressed by some other professionals for their own separate units, and despite some history of separate representation of each profession, mainly in New York (see, e.g., Friedman, 5038), it seems clear to us that to provide for such additional units might create the proliferation which Congress meant to avoid. Moreover, despite the existence of some units combining technicals with other professionals (see, e.g., Willman, 4480, 4483, 4485, 4486; Shea, 5208; Robfogel, Chi. II, 224), Sec. 9(b)(1) of the Act prohibits such a combined unit, unless the professionals separately vote for inclusion with the non professionals. Accordingly, based on the above, we affirm the appropriateness of a separate unit of all professional employees, other than RNs and physicians.

VIII. Technicals

A. Introduction

In our Notice of Proposed Rulemaking, we tentatively determined that technical employees constituted a separate appropriate bargaining unit. Among the reasons we expressed were:

> (a) That, in comparison with other non-professionals, they typically have significantly higher levels of skill and training, and are paid substantially more;
>
> (b) That it has been the Board's consistent practice to approve separate units of technical employees; and
>
> (c) That these separate units generally have met with approval from the courts of appeals.

After carefully considering the evidence presented during the rulemaking proceedings, we have determined that technical employees appropriately constitute a separate bargaining unit.

B. Technical Employees Are Separate and Distinct From Other Non-Professional Employees

1. *Education, licensing, training, and skills.* Technical employees are found in major occupational groups including: medical laboratory, respiratory therapy, radiography, emergency medicine, and medical records.[23] (WS McKinney, 2.) The evidence presented at the hearings demonstrates that technical employees perform jobs involving the use of independent judgment and specialized training, as opposed to service and maintenance employees who generally perform unskilled tasks and need only a high school education (AFL Br. 32, citing *Southern Maryland Hospital Center*, 274 NLRB 1470 (1985); McKinney, 5502-03, 5523-24; Colbert, 5020; WS Shea at 20). Testimony indicated that the gap between technical employees and service and maintenance workers actually is widening, with higher levels of technical skills more closely aligned to professional job categories rather than to other non-professional categories (WS Shea at 20; WS

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[23] Although we note that historically, those employees who enter and decode patient data in medical records have been placed in service and maintenance units or overall non-professional units (see e.g., *Levine Hospital of Hayward*, 219 NLRB 327 (1975); Duke University, 226 NLRB 470 (1976)), the inclusion of "medical records technicians" in a separate technical unit may be litigated as a unit placement issue when it arises, on a case-by-case basis.

Schoen at 14 and 5175-76). Thus, technical employees occupy a high-prestige status distinct from other categories of non-professional employees because of the training requirements for their jobs (WS Cornfield at 12-13).

Technical employees further are distinguished by the support role they play within the hospital, and by the fact that they work in patient care. Examples of their work include: routine clinical tests performed by medical laboratory technicians; general respiratory care administered by respiratory therapists; and x-rays, ultrasound procedures, and CAT scans performed by various technicians. (WS Briguglio at 3.)

Contrary to the AHA's statement that "no evidence of separate or distinct employment attributes of technical employees was presented at the hearings" (AHA Br. 33), the evidence shows that all health care technical employees have significant additional education and/or training beyond high school, including: community college associate degree programs which provide math and science background beyond that which high schools offer (WS McKinney at 5); vocational training programs run by hospitals (WS McKinney at 7); programs at accredited schools of technology (WS Briguglio at 2); and, in some fields, a full 4-year college degree (Schoen, 5176; McKinney, 5477).

Further, the evidence indicates that most hospital technical employees are either certified (usually by passing a national examination), licensed, or required to register with the appropriate state authority (Willman, 4474), although laws regarding such licensure, registration,

training and qualifications vary throughout the country (Ahmed, 3709-11).

There was evidence that some deskilling is occurring in the technical categories, reducing the need for higher skills in operating some equipment; however, the evidence further shows that it is not across-the-board (McKinney, 5485). Further, hospitals must purchase expensive and complicated equipment to deskill a task (McKinney, 5486); and where, for example, a technologist's work may be deskilled, it then would be performed by a technician rather than by a service worker (McKinney, 5513-14; Berliner, 5633-34).

2. *Wages, hours, and working conditions.* Although, in general, hospitals apply similar benefit and labor relations policies to technical and other non-professional employees, the evidence shows that the wages and hours of technical employees differ significantly from those of the other non-professionals (Mass. Hospital Assn., Comment 105). Technicians were shown to occupy the middle ranks in the hierarchy of health care workers, and the evidence presented regarding hospital pay scales reflects this standing (WS Schoen at 15). On the average, technicians earn $2,000 per year more than service workers in this industry (WS Schoen at 15, Table 1; Henry, 3084-85). While the wages of service workers are tied to the unskilled labor market, and those of business office clericals and skilled maintenance workers are similar to those of comparable jobs outside the industry, technicians' wages are tied to the earnings of the more highly skilled technologists with whom they work, and they generally earn approximately 75% of what the technologists earn (WS McKinney at 12-13, & 5479). Thus, management

needs to provide higher entry wages for technicians than for service workers (Shea, 5238-39; Briguglio, 5300-01; Henry, 3084-88).

Technical employees work daytime hours, with evening, night, and weekend skeleton crews, while business office clericals work daytime hours and service and maintenance employees are staffed on a 24-hour basis (Colbert, 5016-17).

3. *Supervision*. The evidence indicates that technical employees usually have separate supervision from other non-professional employees; however, this may differ from facility to facility. For example, a supervisor of some technical employees may also supervise business office clericals; or a laboratory manager who supervises technical employees also may supervise some service and maintenance employees. (Mass. Hosp. Assn., Comment 105; Briguglio, 5300.)

4. *Contact with other employees*. Technical employees typically perform their work in laboratories or in technical departments, and not in patient care areas (AFL Br. 41; Booth, 3693), although the AHA's brief states that more hospitals are beginning to locate some laboratory facilities in patient care areas and technicals may have direct and continuing involvement with other categories of employees as well as with patients (AHA Br. 33). The tasks that technicals perform, such as processing and reviewing patient specimens, taking x-rays, EKGs and EEGs, are considered ancillary services, diagnostic in nature (AFL Br. 41). Technicals have no contact with business office clericals, and only minimal contact with service employees, but in a typical laboratory, work with

doctors, technologists, clericals, and messengers (WS Briguglio, 4-5; Colbert, 5017-18; AHA Br. 33). The evidence shows that LPNs do work in patient care areas and provide direct patient care; however, the Board has found them to be appropriately included with technicals in light of their skill level and the requirement that they be licensed (AFL Br. 41 citing NLRB Exh. 5, revised).

5. *Cross training*. There is no temporary interchange, and little permanent interchange between technical employees and other non-professionals because of the difference in skills, the specialized functions of the technicals, and the differences in their education (Shea, 5221-22). Service workers typically have only a high school education or less and cannot be placed in technical positions in the absence of elaborate training programs (McKinney, 5481). Contrary to statements of industry witnesses who maintain that a service worker could take a six-week training program and be able to read EKG equipment (King, 5488), we are persuaded that technical training requires full or nearly fulltime education, and a high school education does not provide the mathematics and science background necessary (WS Shea at 21).

The evidence shows that cross-training programs are being offered at some hospitals and colleges; however, training programs and funds to provide classroom instruction for hospital employees are rare in hospitals that are not unionized (Schoen Supplemental Statement). Thus, the majority of cross-training that occurs is among the technical categories themselves (LPNs doing EKG work formerly done by EKG technicians; medical technologists administering blood gases previously administered by respiratory technicians) (St. Anthony's Health Corp.,

Comment 142; St. Joseph Mercy Hospital, Iowa, Comment 243). Moreover, new technology has brought about a decline in technician jobs requiring only minimal training, while increasing the need for more intensely-trained technicians, thus widening the gap between technical employees, who are becoming more skilled and sophisticated, and service and maintenance workers (WS Schoen, 14-15; WS Shea at 21).

6. *Career paths and the labor market.* Technical employees have a separate career path and labor market. They do not seek to transfer into other types of non-professional jobs; rather, technicians may seek to become technologists in the same line of technical work; or LPNs may seek to become RNs. (O'Cleireacain, 5426; Ryan, 4738-39.) While some LPNs may become RNs through training programs, progression to technologist is more difficult for technicians because of the 4-year college requirement for many technological positions (WS Schoen at 15; McKinney, 5477). Their existing training is not considered a "building block" toward technologist status, without successful negotiations with licensing and accreditation boards (Schoen, Supplemental Statement). Thus, in addition to little mobility in their immediate workplace, it is also difficult for technicians to move out of that workplace. As long as they wish to practice their specialities, they must remain in the health care industry. (WS McKinney at 12.) Statistics show that 100% of job placements from technical programs are in health care occupations (Ryan, 4744). In contrast, business office clericals and skilled maintenance workers have great mobility outside the industry, as do unskilled service employees (O'Cleireacain, 5427; Marshall, 4018-19).

Evidence presented at the hearings shows that the labor market for technicians, which until recently was expanding steadily, is contracting (McKinney, 5474, 5478). Witnesses testified that with the introduction of cost containment techniques into the industry, the future of technical workers is in a state of flux. Further, even though new technology and equipment continue to be developed, at the same time hospitals are seeking to save on labor costs by replacing expensive, skilled employees, closing laboratories, and contracting out laboratory services. (WS McKinney at 13; Berliner, 5598.) Certificate of Need programs impose limits on the addition of new technology, further reducing the need for new technicians. For all of these reasons, training programs have become an important bargaining issue. (Schoen, Supplemental Statement.)

C. *Organizing and Bargaining*

The health care industry's bargaining unit proposals in 1973-74 would have allowed a separate unit for technical employees in hospitals (AFL Br. 31); and since 1974, the Board has continued to find separate technical units appropriate (NLRB Exh. 5, revised; *Southern Maryland Hospital Center,* 274 NLRB 1470 (1985)). As we noted in our proposed rule, court decisions have approved the Board's determinations as to technical units. See, e.g., *Watonwan Memorial Hospital v. NLRB,* 711 F.2d 848 (8th Cir. 1983); *NLRB v. Sweetwater Hospital Association,* 604 F.2d 454 (6th Cir. 1979). See also *Vicksburg Hospital v. NLRB,* 653 F.2d 1070, 1075 (5th Cir. 1981). Further, the evidence shows that technicals choose to organize in technical groups and not with other non-professionals

(Booth, 3686-88). In the 588 hospitals in which a union affiliated with the AFL represents at least one bargaining unit, there are 311 separate technical units (including LPN units), and only 52 units in which technical employees and other non-professionals are combined into a single bargaining unit (AFL Br. 44 and Appendix A; Booth, 3688-90). In addition, LPNs organize with technicals who have the same training, education, licensure, and certification requirements (Muehlenkamp, 4787).

Organizing drives are initiated by employees with specific concerns and grievances (WS Splain at 4; Sackman, 3592; Schmidt, 3628; Muehlenkamp, 4784). Other interests include professional conferences, training, and rotations (Colbert, 5019). At the hearings, no union organizer who was asked could recall any situation in which technical employees sought to include business office clericals or unskilled service workers, or vice versa (Olson, 4718; Muehlenkamp, 4784).

Technical employees generally choose to have separate initial contracts; however, they may agree, after the initial agreement expires, to engage in joint bargaining, but retain separate delegates for negotiations and for presenting separate issues (Booth, 3688; Colbert, 5021-22). Although industry witnesses maintain that the fact that technical employees organize and bargain their first contract as a separate unit does not justify finding a separate technical unit appropriate where subsequent bargaining history shows that they now bargain in broader units (St. Luke's/Roosevelt, Comment 224; AHA Br. 32-33), there is evidence that difficulties have arisen occasionally where technicals have been included with maintenance

employees and clericals because of their different training, duties, and wages (Logan, Comment 150, pp. 3-4).

D. Proliferation

Technical units generally encompass a wide range of classifications, including LPNs, and they constitute approximately 17% of the health care work force – a substantial complement of workers (WS McKinney at 2; WS Schoen at 3, 5). What evidence there is shows that strikes involving technical employees alone are rare. In New York City, for example, strikes involving technical employees occur in broader units of clericals, service and maintenance, and professional employees. (Long Island Jewish (LIJ) Medical Center, Comment 270.)

E. Other Issues

The label "technical" may no longer define a particular group of jobs, and indeed, the union witnesses who appeared at the rulemaking hearings often did not distinguish between technicians and technologists (Schoen, 5175; Ahmed, 3709-11; McKinney, 5471-79; WS Briguglio at 2-3.) Technologists often have been included as professional employees in professional-only units. See, e.g., *Children's Hospital of Pittsburgh*, 222 NLRB 588 (1976); *Mercy Hospitals of Sacramento*, 217 NLRB 765, 769 (1975). Although industry witnesses urge the Board to consider the practical effect of the difficulties of resolving issues of unit placement, and caution that there may be "intense litigation" over unit placement which could be avoided by the inclusion of technicals in a broad non-professional unit (AHA Br. 34), we note that, even with such inclusion,

litigation could continue to occur over which technicians were professional employees. Individual placement issues always have been present in the consideration of health care and other cases. In our opinion, their existence should not deter the Board from taking the first step, i.e., determining the threshold appropriateness of a separate technical unit.

F. Conclusion

For the above reasons, we determine that separate technical units are appropriate for collective bargaining. The evidence clearly demonstrates that the varied technical employees employed in the health care industry are appropriately grouped into a single unit by virtue of their education, training, and specialized skills, and do not constitute a unit so large as to be overly diversified and hence unwieldy for organizing and collective bargaining.

IX. Skilled Maintenance

A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that service and maintenance employees constituted a separate appropriate unit and that skilled maintenance employees should be included in that unit rather than represented in separate skilled maintenance units. Among the reasons we expressed for including skilled maintenance employees in the broader service and maintenance units were:

> (a) That their skill levels do not, at times, greatly exceed those of other service and maintenance unit employees;

> (b) That they work throughout hospital's facilities, and thus frequently come into contact with other service and maintenance employees;
>
> (c) Their inclusion in broader units will help to prevent unit proliferation; and
>
> (d) As a practical matter, the Board's approval of separate maintenance units had fared poorly in the courts.

After carefully considering the evidence amassed during the rulemaking hearings, we have determined that, contrary to our earlier impressions, skilled maintenance employees can and should constitute a separate appropriate bargaining unit.

B. Relationship to Other Employees

1. *Functions and skill level.* Evidence from the rulemaking hearings shows that skilled maintenance employees perform functions apart from those of unskilled service, maintenance, and clerical employees in that these employees deal with highly complex and sophisticated systems and equipment (Carrick, 3448-3450; Jacquin, 5354-55; Lake, 146-148). While they occasionally perform routine, unskilled tasks, skilled maintenance employees are generally engaged in the operation, maintenance, and repair of the hospital's physical plant systems, such as heating, ventilation, air conditioning, refrigeration, electrical, plumbing and mechanical (Lake, 150-151; Viat, 3457-59, 3476-77; Hach, 5318; Giblin, 5382-83). Work on these systems requires abstract skills and knowledge at levels considerably higher than those

of other non-professional hospital employees (Marshall, 4010-4012; Hammond Exh. 1, pp. 340-45, 580-623; Cornfield, 5698; WS Cornfield at 4-6, citing Dictionary of Occupational Titles of U.S. Employment and Training Administration). Skilled maintenance employees are rated more highly, for example, even than physicians on the manipulation of "things" (WS Cornfield at 5). Skilled maintenance employees are frequently required to have postsecondary training in their field, such as vocational or trade school. Even the lower skilled maintenance employees in plant operations and maintenance are required to have higher skills than those required of service employees. (Jacquin, 5363-64, 5374, 5377; Viat, 3459-60; Giblin, 5384.)

2. *Education, licensing, and training*. Contrary to virtually all nonsupervisory service classifications, which require only a grade school education, skilled maintenance classifications require completion of high school; at least some trade or vocational school experience, if not graduation therefrom; completion of formal or informal apprenticeship programs, which may take several years; or an associate's or bachelor's degree (Hammond, 5404-05, 5409-12; AHA Health Care Occupations: A Comprehensive Job Description Manual pp. 340-45, 385-88, 394-402, 499-501, 561-62, 567-70, 573-74, 580-623; Marshall, 4010). Skilled maintenance employees also need continuing education to keep abreast of technological changes in building maintenance, such as computers and remote controls (Carrick, 3454; Marshall, 4011-12; Schloop, Chi II 165; Schwemm, Chi II 186-89; Hammond, 5408; WS Schwemm, Exh. 5-9; WS Fowler at 4; WS Denevi at 7-9). Moreover, the amount of training available in

skilled maintenance classifications compares favorably to that offered in various technical classifications, such as lab technician and medical records technician (WS McKinney at 6-7), and access to the programs and the upward mobility they bring provide a common concern to employees largely unshared by those outside the skilled maintenance group (Schloop, Chi II 165; Ryan, 4739). Another distinction between skilled maintenance and unskilled service employees is that at least seven skilled maintenance classifications, but no service classifications, require licenses. (Hammond, 5404-06; WS Cornfeld, at 6-8)

3. *Supervision*. The distinct nature of skilled maintenance functions is underscored by the frequent placement of skilled maintenance employees in separate departments, usually coinciding with the hospitals' plant engineering or maintenance departments (Carrick, 3448; Viat, 3457, 3478; Marshall, 4014; Hach, 5342, 5354). Thus, skilled maintenance employees frequently have their own supervision (Hammond, Exh. 1, pp. 581-590). Moreover, skilled maintenance employees are not supervised by any supervisors from outside their own departments (see, e.g., WS Fowler at 8).

4. *Wages, hours, working conditions*. While it appears that certain terms and conditions of employment, i.e., fringe benefits and personnel policies, are similar among non-professional employees (Jacquin, 5368-70; Comer, Chi II 326-29; Comment 129, Hall), wage rates paid to skilled maintenance employees underscore their higher skills and training. Thus, the most recent Industry Wage Survey: Hospitals, Aug. 1985, BLS of the DOL, shows that skilled maintenance employees in private hospitals in 23

metropolitan areas averaged $11.89/hour whereas, in comparison, employees in six service classifications averaged $6.84/hour, office clericals in five classifications averaged $7.56/hour, and employees in ten technical classifications averaged $9.89/hour. (Lake, 154-55; IUOE, Exh. 4.) Thus, on the average, skilled maintenance employees earn 25% more than technicians, almost 60% more than business office clericals, and 76% more than service employees. Moreover, the wage rate of lesser skilled maintenance employees, while lower than that of the most skilled maintenance employees, almost always exceeds that of even the highest-paid service employees and often exceeds the rate of employees in other classifications as well.

5. *Interaction with other employees*. Though they primarily work in maintenance areas, skilled maintenance employees do perform work throughout the hospitals (Kelly, Chi II 178; Carrick, 3453; Hach, 5330). As a result, skilled maintenance employees have contact with just about every other employee in a hospital. However, these contacts are brief, limited, and incidental as it appears that the only employees with whom skilled maintenance employees actually work are others from the maintenance department (Carrick, 3453-54; Jacquin, 5360; Kelly, Chi II 212-13), and that the contacts with nonmaintenance employees typically consist of other employees' identifying the maintenance problem to the skilled maintenance employees (Kelly, Chi II 178, 213; Jacquin, 5360; WS Fowler at 8).

6. *Labor market and career paths*. Skilled maintenance employees have separate labor markets and highly mobile cross-industrial career paths as the operation and

maintenance of physical plant systems are the same no matter in which industry they are performed (Marshall, 4014; Schloop, Chi II 163; Kelly, Chi II 177; Fox, 3436-37; O'Cleireacain, 5427; WS Denevi at 4). Easy mobility in skilled maintenance classifications tends to orient these employees toward their skills rather than the industry in which they are employed (Lake, 144, 490; Marshall, 4010, 4019). The external skilled maintenance labor market also affects the hiring and wage scales in the health care industry since hospitals compete with other industries, such as hotels and office buildings, for these employees (Berliner, 5645; Hach, 5344-45; WS Schoen at 23; Corbett, 3344-45).

Skilled maintenance employees are in a separate internal labor market within the hospital in terms of career path, training, and promotion. There are formal and on-the-job training programs to permit lower level maintenance employees who have acquired skills and knowledge to move into more highly skilled positions; yet, there is virtually no transfer of clerical or service employees into maintenance classifications. (Schloop, Chi II 204-05; Kelly, Chi II 216-17; Giblin, 5400; O'Cleireacain, 5427, 5468; WS Shea at 18.) Even entry level jobs are filled by those with skilled maintenance backgrounds (Hach, 5327; Schloop, Chi II 203-04).

C. *History of Representation*

The appropriateness of separate skilled maintenance units is supported by a history of separate representation, especially by labor organizations specializing in the separate representation of skilled maintenance employees

(IUOE Exh. 2 revised; Holland, Chi II 305-09; Friedman, 5036, 5040-41; Peters, Chi II 131-34; Comer, Chi II 320, 327-28; Hach, 5328; Giblin, 5395). For example, the IUOE currently represents at least 237 separate skilled maintenance units in both private and public health care institutions nationwide (IUOE Br. 56). Twenty percent of IUOE health care units date from the 1940's and '50's, and 85% of them predate the 1974 amendments (IUOE Exh. 2 revised). Admittedly, there are skilled maintenance employees represented in combined service and maintenance units, or in a handful of broader non-professional units, but inclusion of skilled maintenance employees with these other employees does not necessarily show a voluntary grouping as some combined units are the result of stipulations so that elections could be held without further delay, or are atypical situations (Stickler, Chi I 16-26; Twomey, 131-34; Emanuel, 3497; Ratner, 3728; AHA Exh. 4-9; Willman, 4491-92; Muehlenkamp, 4767; Friedman, 5041; King, 4244, 4249, 4251-52). In addition, the evidence regarding combined units is equivocal in that the "maintenance" employees in "service and maintenance" units are frequently unskilled rather than skilled maintenance employees (Silberman, 5651; IUOE Br. 58; Shea, 5227-28; Splain, 5302-04).

D. Organizing and Bargaining Interests

1. *Organizing*. Though clearly not impossible, it appears that because of the variety of personal interests involved it is more difficult to organize larger, combined units than to organize separate smaller units of employees (Viat, 3465; Sackman, 3578; Schwarz, 265; WS Schwarz, Koziara study p. 1, 4, Figure 1; Delaney,

4517-18, 4525; Silberman, 5686; AFL Exh. 2). Larger heterogeneous units deter decertifications of unions as well (Delaney, 4523). In addition, skilled maintenance employees usually do not wish to organize with other groups, and it is unusual for different groups of non-professional employees to seek to organize in the same unit (Muehlenkamp, 4785; Olson, 4698-99; Ratner, 3730). There is evidence that, where combined units are sought, separate interests of the diverse groups may make it difficult, or impossible, to hold organizing meetings of the entire group (Viat, 3465).

2. *Bargaining interests*. While all employees have some similar bargaining concerns, i.e., wages, hours, and fringe benefits, skilled maintenance employees have additional interests different from those of other non-professional employees. They seek wage levels commensurate with those of skilled maintenance employees in other industries; access to craft-related education and training programs; tool supply allowances; safety equipment and practices; portable pensions, because of their cross-industrial mobility; and input with respect to subcontracting of work. (Kelly, Chi II 175; Marshall, 4011; Willman, 4492-93; Schloop, Chi II 164-65; Schwemm, Chi II 209; Viat, 3466-67; Giblin, 5388.) Service employees and business office clericals have specialized bargaining interests as well (Schloop, Chi II 168; Viat, 3466-67; Gregory, 5746). These differences lead to difficulties in bargaining in a heterogeneous group, and may result in the smaller group of skilled maintenance employees getting lost in the shuffle in negotiations relating to the more numerous lesser skilled employees (Schloop, Chi II 168-69; Olson, 4729-30; Viat, 3465; Willman, 4492; Ratner, 3734; Shea,

5187; Meuhlenkamp, 4795-96). Negotiating in a broader unit may also serve to broaden the scope of labor disputes by involving employees whose personal interests are not of concern in disputes relating to the interests of other unit employees (Viat, 3466). For example, in one hospital in which two unions jointly represented a combined unit of service, skilled maintenance, technical, and plant clerical employees, the skilled maintenance employees were forced to join other employees in a strike over unresolved bargaining issues that affected only the other employees even though all issues involving the skilled maintenance employees had already been settled (Viat, 3466).

E. Proliferation

Contrary to our concern, as expressed in our NPR, there was no evidence adduced at the rulemaking hearings that establishing a separate unit of skilled maintenance employees will lead to proliferation of bargaining units in the industry (Kelly, Chi II 180; Gilmore, 4894; Splain, 5252). No labor organizations have sought or demonstrated the appropriateness of other small units (IUOE Br. 64-65). Moreover, the skilled maintenance employee unit may be viewed as a consolidation of specialized employees inasmuch as it combines such employees as carpenters, painters, plumbers, and electricians (IUOE Br. 65). The only employee classification performing work similar to that performed by traditional craft or trade-type maintenance employees are biomedical technicians (Marshall, 4018-20; Hach, 5346-49; Jacquin, 5377; Viat, 3480-81; Giblin, 5396-98). Biomedical technicians work on and repair sophisticated computer-based

equipment, and because of both their skills and training share a community of interest with other skilled maintenance employees and in many instances have already been included in some such units (Fox, Exh. 1 and 2; Hammond, Exh. 12; Viat, 3458, 3460, 3480; Giblin, 5495-97; Marshall, 4019-20; McKinney, 5497, 5525; Hach, 5347-49; Jacquin, 5377; Schloop, Chi II 203-04; Carrick, 3448).

F. Strikes, Sympathy Strikes, Jurisdictional Disputes, and Wage Leapfrogging or Whipsawing

1. *Primary strikes.* The evidence taken at the rulemaking hearings shows that the presence of separate skilled maintenance units has not resulted in a large number of strikes by these units (Lake, 157; IUOE Exh. 2; Viat, 3468; Schloop, Chi II 169; Kelly, Chi II 180; Hach, 5323; Giblin, 5389; Hammond Exh. 12, attached affidavits). The hospitals contend that the number of strikes is low because the number of employees involved is small and therefore the cost of a strike exceeds the potential increase in labor costs of the union's demands thereby making it more likely that hospitals will give in to those demands. Nonetheless, the fact remains that in the 237 skilled maintenance units represented by the IUOE, in which hundreds of contracts have been negotiated, there have been only about 25 strikes ever (Lake, 157; IUOE Exh. 2). In addition, the incidence of strikes by skilled maintenance employees has not increased in proportion to the number of other represented units of hospital employees (IUOE Exh. 2; Viat, 3468-69; Fox, 3442). The few strikes that have occurred have been almost exclusively in support of bargaining demands, and have not

been disruptive to health care delivery; indeed, skilled maintenance employees have offered to provide skeleton crews to assure uninterrupted service in the event of a work stoppage (Henry, 3059; Fox, 3442; Viat, 3467-68, 3470; Hammond Exh. 12, affidavits of Bess, Tighe, and Scheb.) Moreover, other hospital employees, whether represented or not, generally have not engaged in work stoppages in support of striking skilled maintenance employees (Hammond Exh. 12, affidavits of Bess, Tighe, and Scheb).

2. *Sympathy strikes*. While the strike rate in the health care industry in general is low (Subrin, Chi I 119-20; Schoen, 5181; Silberman, 5659), there is evidence that hospitals have not availed themselves of the opportunity to limit the possibility of successive multiple strikes by supporting union proposals for common contract expiration dates of different units' contracts; indeed, hospitals have opposed such proposals. (Henry, 3075; Absalom, 3318-19; Corbett, 3359-60; Schmidt, 3625; Weinrich, 4274; Muehlenkamp, 4771, 4774). Moreover, there have been virtually no sympathy strikes by skilled maintenance employees in support of other striking hospital employees (Schloop, Chi II 169; Kelly, Chi II 180; Fox, 3442; Friedman, 5060; Hach, 5323: Jacquin, 5361; Giblin, 5389; WS Fowler at 7; Hammond Exh. 12, affidavits of Bess, Tighe, and Chambers). No-strike clauses, which are generally honored, appear to have contributed to the infrequency of such strikes (Fox, 3442; Friedman, 5060-61). And, while the evidence shows that bargaining in broad, heterogeneous groups may serve to expand the scope of a strike by involving employees whose personal interests are not of concern in disputes relating to the

interests of other unit employees (Viat, 3466; see above discussion in subsection (d)(2), Bargaining Interests), it also shows that the absence of sympathy strikes in the industry makes it unlikely that such expansions of strikes will occur where employees with separate and distinct interests are represented in separate units.

3. *Jurisdictional disputes*. In general, industry witnesses were unable to support the allegation that allowing separate skilled maintenance units would increase the number of jurisdictional disputes in the industry (Graumann, 409; Weinrich, 4254, 4281; Cammarata, 4406). Instead, the evidence shows that jurisdictional disputes over work assignments involving skilled maintenance employees are, like those in the hospital industry in general, rare and nondisruptive (Roth, 3153; Muehlenkamp, 4775; WS Shea at 14). Moreover, we are persuaded that the types of jurisdictional disputes which do arise, i.e., disputes over job classification, content, and responsibility, occur regardless of whether the employees are represented in one unit or several different units (Krasovec, 420-22; Hach, 5324; Giblin, 5389-90; WS Shea at 14). Finally, the few disputes which have arisen have been resolved informally, minimizing disruption of normal operations (Schloop, Chi II 170-71; Kelly, Chi II 181, 206, 207; Fox, 3442-43 & Exh. 2; Viat, 3471; Hach, 5323; Jacquin, 5361; Giblin, 5389).

4. *Wage whipsawing and leapfrogging*. Wage whipsawing or leapfrogging virtually never occurs with skilled maintenance units inasmuch as the wages of skilled maintenance employees are generally based on the wages of skilled maintenance employees in other industries,

rather than on the wages of other health care industry employees (Corbett, 3344; Hach, 5344-45).

G. Changes in the Industry

The alleged trend toward specialized hospitals and integration of employee functions would appear to have no impact on skilled maintenance units because the physical plant systems will essentially remain the same and will require skilled maintenance employees to operate and maintain them (Viat, 3470). Any move toward interdisciplinary teams also appears to have had no effect on skilled maintenance employees as virtually every team that was described by the industry included only health care personnel (Mixon, Chi II 275; Gallagher, 3541-42; Houston, 4025, 4050-55; Donnelly, 4064, 4080; Sokatch, 4195; Weinrich, 4268-69; Comment 62, Achterhof; Comment 78, Olman Greater Cincinnati Hospital Council). The one example provided at the hearings of skilled maintenance employees' participating on a team involved the skilled maintenance employees' voluntarily critiquing vocational training projects of rehabilitation patients (Coney, 165). This one example of an incidental function undertaken by a maintenance group at one hospital is, so far as we know, unique, but in any event does not involve direct patient care and is clearly insufficient to obliterate their distinct functions. Finally, the industry gave no examples of skilled maintenance employees being cross-trained into other job groups such as clericals or service employees and, cross-training from service to skilled maintenance positions or technical positions is virtually unknown. (Stickler, Chi I 9, 33-37; Houston, 4026; O'Cleireacain, 5467-68; McKinney, 5481.)

H. Other Issues

1. *Costs of multiple units with reference to skilled maintenance.* Assuming the relevance of the potential cost to the industry of negotiating in additional units, the evidence does not support the conclusion that units of skilled maintenance employees would necessarily have any adverse effect on hospitals' expenses. The evidence there is shows that contract negotiations for skilled maintenance units tend to be relatively short, which means relatively inexpensive (Comer, Chi II 328; Viat, 3469; Jacquin, 5378).

2. *Congressional admonition against proliferation.* The admonition against proliferation of units was directed toward problems that could be caused by having many separate bargaining units, i.e., substantial numbers of strikes interfering with the delivery of health care services, wage whipsawing, and jurisdictional disputes. As shown above, there is little or no evidence that the existence of separate skilled maintenance units has resulted, or would in the future result, in these problems. As a practical matter, permitting separate skilled maintenance units would not necessarily result in the creation of still additional bargaining units since most hospitals have substantially fewer organized units than the number proposed by either the Board or the unions. (Schwarz, 264, WS Table 1; Robfogel, Chi II 223; Comer, Chi II 329; Cammarata, 4425; Delaney, 4520; Muehlenkamp, 4770-71; Shea, 5163.)

During the 1973 legislative hearings on S. 794, the fear expressed by a number of witnesses was that Board precedent might permit a separate unit for each trade or

craft found in hospitals. Thus, e.g., Sidney Lewine, testifying on behalf of AHA, and Richard V. Whelan, Jr., representing the Ohio Hospital Association, noted with apprehension the proliferation that would result if the Board were to grant a separate unit to each construction craft such as stationary engineers, carpenters, plumbers, electricians, pipefitters, and painters. (Coverage of Nonprofit Hospitals Under National Labor Relations Act, 1973, Hearings on S. 794 and S. 2292, at 128-29, and 465-66, respectively.) The Board's proposal directly takes into account this concern, which was called to Congress' attention, by putting all such separate skilled crafts into *one* skilled maintenance unit.

3. *The most recent Board decision.* In *St. Francis Hospital*, 286 NLRB No. 123 (Nov. 30, 1987) (*St. Francis III*), the Board held that a separate maintenance unit was inappropriate. In so doing, the Board found that the hospital's maintenance employees constituted less than 10% of the hospital's 438 service and maintenance employees, and spent approximately 80-95% of their time working throughout the hospital, thus bringing them in frequent contact with all other hospital employees. The Board further found that the hospital used independent contractors to perform difficult work, and that the sought employees shared the same basic terms and conditions of employment as service employees, including departmental supervision. The Board also noted that its finding that these particular maintenance employees did not constitute a separate appropriate unit was based on the particular facts of the case and was in no way an expression of its view concerning the appropriateness of maintenance units in general. Based on the evidence obtained during

the rulemaking hearings, it is unlikely that we would reach the same result. Thus, the evidence from the hearings shows that, in virtually all health care facilities which were the subject of testimony at the hearings, skilled maintenance employees constitute a discrete and distinct group of employees. They perform functions apart from those of unskilled service, maintenance, and clerical employees. Skilled maintenance employees were shown to be highly skilled as evidenced by higher educational, licensing, and training requirements. While they share some common terms and conditions of employment with other hospital personnel, these employees uniformly have higher wages than service and clerical employees and have a number of bargaining interests separate and distinct from those of non-maintenance employees, such as access to craft related education and training programs, tool supply allowances, safety equipment and practices, portable pensions, and the like. Moreover, while skilled maintenance employees do work throughout the entire hospital, their contact with non-maintenance employees is brief and limited. Finally, the hearing evidence shows that transfers are rare in the industry and that skilled maintenance employees have a separate internal and external labor market.

I. Conclusion

For the above reasons, we find that a unit of skilled maintenance employees is separately appropriate for collective bargaining purposes. Although the number of employees in such a unit will be relatively small, their work bears little relationship to that of other hospital employees. It is, essentially, a non-health care occupation

involving skills, interests, and job markets largely separate from the hospital itself. For that reason, to require unions to organize and represent skilled maintenance employees as part of a larger group of unskilled employees performing health-related jobs within the hospital is both unrealistic and inefficient. Hence, we have decided that the final rule should provide for separate skilled maintenance units.

The IUOE contends (IUOE Br. 9), and we find, that skilled maintenance units should generally include all employees involved in the maintenance, repair, and operation of the hospitals' physical plant systems, as well as their trainees, helpers, and assistants. However, evidence from the hearings shows that it may not always be possible to identify in advance those employees properly included in this unit, partly because employees performing essentially the same functions are classified differently in different hospitals. Thus, for example, in Los Angeles and San Francisco all employees represented by the IUOE in skilled maintenance units are classified as stationary engineers regardless of their particular job functions (Viat, 3457-58; Hach, 5318) whereas in Chicago, New York, and New Jersey most health care employers have retained craft titles for their employees. (Schloop, Chi II 203; Schloop affidavit; Hach, 5318; Giblin, 5383.) In addition, many skilled maintenance classifications are subdivided by skill or experience level, e.g., master level, journeyman level, apprentice, and/or helper. Among the employee classifications which should generally be included in such units are carpenter, electrician, mason/bricklayer, painter, pipefitter, plumber, sheetmetal fabricator, automotive mechanic, HVAC (heating, ventilating,

and air conditioning) mechanic, maintenance mechanic, chief engineer, operating engineer, fireman/boiler operator, locksmith, welder, and utility man. (Health Care Occupations: A Comprehensive Job Description Manual, Chapter XXXII; Hammond, Exh. 12, affidavits of Bowen, Tighe, Chambers, Scheb, McWade, Scadden, Kelly, Schloop, Gindorf, Fox, Lane, Belfi, and Bess.) As noted above, sometimes relatively unskilled utility workers are included, either if they are involved in the maintenance, repair, and operation of hospitals' physical plant systems (Viat, 3460), or if they are part of a separate maintenance department. This list is not exhaustive; rather, it is illustrative of the types of employee classifications exhibiting the characteristics which the rulemaking record shows are typical of employees included in skilled maintenance units. Because of this variation, in some instances it may be necessary to decide by adjudication the unit placement of individuals in particular job classifications. However, this is also true with respect to technical and business office clerical units, for example. It does not defeat the basic appropriateness of the unit as found in this rulemaking proceeding.

X. Business Office Clericals

A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that business office clericals should be included in a unit of service and maintenance employees, rather than represented in a separate unit. 52 FR 25147. Among the reasons for including business

office clericals in the broader service and maintenance unit were that they:

(a) Often share many terms and conditions of employment with service and maintenance employees;

(b) Have regular and frequent contact with service employees;

(c) Are engaged in recordkeeping as are ward clericals, technicians, nurses, and physicians;

(d) Have not been represented historically by labor organizations specializing in representing business office clericals; and

(e) Their inclusion in the broader unit will help unit proliferation.

After carefully considering the evidence amassed during the hearing, contrary to our tentative determination we have concluded that for the following reasons the business office clericals constitute a separate appropriate bargaining unit.

B. The Record Supports a Finding That Business Office Clericals Constitute a Separate Appropriate Unit

1. *Job duties and functions.* Evidence from the rulemaking hearings shows that although many hospital employees perform some recordkeeping functions, business office clericals perform substantially different functions from those performed by other employees (WS Holtz at 8-9; WS O'Neil at 1 & 5526-29). Business office clericals are primarily responsible for a hospital's financial and billing practices (WS Winn at 6-7), and deal with

Medicare, DRGs, varying price schedules, multiplicity of insurance types, and new reimbursement systems (WS Schoen at 9; Berliner, 5599-5600). Increasing computerization of financial management has led to specialization and has reduced the clerical duties of other hospital employees (WS Schoen at 11).

One argument advanced by some employers is that many different professional and non-professional classifications use computers; 2/3 of the hospitals are considering information systems-technology which will enable nurses to enter and read programs reporting patients' test results, medication, and scheduling (AHA Br. 45 citing article in *Modern Healthcare*). Unlike these employees, however, business office clericals do not engage in any form of patient care and are not responsible for the patients' physical or environmental health (Wilkinson, 4973-76; Bryant, 116-118). Moreover, although other clerical and professional employees may be utilizing information systems technology and video display terminals (VDTs), and despite the existence at the University of Alabama (Birmingham) of a training program for "clerical technicians" who learn to do billing, perform blood tests, and take x-rays (AHA Br. attachment 5), it has not been shown that service workers or clinical technicians perform functions similar to those performed by the business office clericals, i.e., they are responsible for selecting, completing, or interpreting business forms using computers, keyboard terminals, and typewriters. Nor was it shown that the University of Alabama program was duplicated elsewhere in the country, or that any person from the program was ever placed in a hospital. (AFL Br. 77). Moreover, the evidence indicates that this program

was clearly intended for technical employees (Stickler, Chi I 37-38).

2. *Education*. Business office clericals generally are required to have a higher level of education than service and maintenance employees, i.e., a high school diploma and specific clerical skills, and a majority of business office clericals have some college background and formal clerical training (WS Nussbaum at 2; WS Cornfield at 6). Moreover, because of the increased complexity of the hospitals' financial operations, including the introduction of DRGs, hospitals have begun to require more training for business office clericals, and to require skills in such areas as programming, coding, abstracting, and billing procedures (WS Schoen at 9; WS Ryan at 1-2). By contrast, service workers have minimal educational requirements, prior work experience is unnecessary, and they are not required to possess special business-oriented skills (AFL Br. 53; WS Cornfield at 8). There is some evidence that admitting clerks and medical records librarians receive vocational training at many of the same business or trade schools as purchasing clerks and accounts receivable clerks (WS Coney at 5). However, no specific evidence was provided regarding the type of training each receives. The fact that some employees are attending the same schools does not establish that they are receiving identical training. Consequently, we do not place great weight on this factor; in any event, whether some of these other classifications are also business office clericals is a matter we do not here decide. Further, business office clericals undergo constant retraining to update current skills or acquire new skills as financial operations are updated (WS Holtz at 5, 9-10).

3. *Terms and conditions of employment*. Although clericals often share some terms and conditions of employment with non-professional employees, especially benefits, evidence from the rulemaking proceeding clearly shows other, significant differences between the business office clericals' terms and conditions of employment and those of the service and maintenance employees. Salaries paid to business office clericals reflect their higher skills and training; a 1985 BLS wage survey shows that business clericals on average earn $2,000 more than the top service jobs (WS Schoen at 12; WS O'Neil at 3). Unlike service and maintenance employees, business office clericals may be permitted to smoke and eat at work stations, and have different dress requirements and health and safety concerns. In addition, unlike most service employees who work varying shifts and weekends, business office clericals generally work one shift, 5 days per week. (AFL Br. 59; WS Nussbaum at 5; Bryant, 116-118; Booth, 3686; WS O'Neil at 2.)

4. *Supervision*. The differences in skills and functions are underscored by the separate supervision of business office clerical departments, which has resulted from the almost universal centralization of business office functions (Berliner, 5597; WS Schoen at 9-10 & 5173). The SEIU survey of 250 facilities showed that at 100% of the facilities, business office clericals have separate supervision. Although clericals occasionally may share supervision with other non-professions (Briguglio, 5300), the evidence establishes that business office clericals regularly have a separate supervisory hierarchy; ultimate supervisory responsibility generally rests with financial administrators as compared to the ultimate supervisory

authority for service employees which rests with administrators overseeing patient care (WS O'Neil at 2; WS Holtz at 4, 6-7). Two examples were given in which clericals and other employees report to the same individual (Briguglio, 5300; Comment 157, Halifax Medical Center). Nevertheless, we are persuaded that, with a few exceptions, business office clericals are separately supervised. Moreover, in one important respect, the nature of the supervision received by the business office clericals is unlike the traditional supervision received by service and maintenance employees. Technology enable supervisors to monitor closely the output of the business office clericals, measured in keystrokes, paper output, volume of bills processed, time on terminals, and phone calls; this monitoring increasingly is used for purposes of discipline. (WS Holtz at 6-7; WS Nussbaum at 2-3.)

5. *Interaction*. Contrary to our original impression, the evidence shows that business office clericals are physically isolated from other non-professional employees and, therefore, have little contact or interaction with them. (Dretchan, 5002; Bryant, 116-118; Booth, 3689-90; WS Nussbaum at 4). The ballooning costs of new construction, as well as increased technology, have resulted in many instances in hospitals' moving administrative offices outside the health care facility into existing buildings at other locations (Berliner, 5602; WS Schoen at 10). Of 250 hospitals surveyed, 35% of the business offices are located in a separate building, 25% are located in a separate wing of the hospital, and 28% are located on a separate floor (WS Shea at 17; WS McKenna at 3-4). Further, centralized processing of information and the increasing use of computerized communication of data

continue to reduce even further the potential for physical interaction (WS Schoen at 14).

6. *Career paths and job mobility*. Business office clericals have few avenues of advancement within health care facilities; rather, they have a separate and increasingly well-defined external labor market (Wilkinson, 4980; WS Ryan & 4749-50). Business office clericals are hired almost exclusively from the external labor market, and hospitals hire business office temporaries as replacements rather than using other hospital personnel. The external market also influences salary scales since hospitals compete with other industries for these employees. (WS Schoen at 11-12; hospitals use BLS wage surveys in determining salaries for business office clericals.) Consequently, while service employees generally remain in health care facilities (WS Berliner at 9-10), business office clericals look elsewhere for other positions if they are dissatisfied.

There is minimal interchange, either permanent or temporary, between employees in service, maintenance, technical or professional jobs and those in business office clerical positions (Ryan at 1-2). Moreover, although one witness testified generally that some clericals receive training to provide direct patient care (Stickler, 16-17 & WS Rhodes at 7), there were no examples of instances where this had actually occurred. There would appear to be little cross-over from clerical positions to patient care positions Further, the evidence reveals that job mobility between service employees and business office clericals is basically nonexistent and, with the upgrading of skills and additional training received by business office clericals, it is becoming even less feasible (WS Lewis at 2-3; WS Blake at 2; WS O'Neil at 2; WS Berliner at 7). In some

hospitals, admitting clerks and medical records librarians, and purchasing clerks and accounts payable clerks are interchangeable and may substitute for each other, and technicals and professionals may handle clerical operations on the night shift (WS Coney at 5; Comment 263, Huntsville Memorial Hospital). Nevertheless, for the most part, even clinical clerical workers cannot shift into business office clerical positions without a substantial degree of retraining and reskilling (WS Berliner at 7). There was testimony that hospitals prohibit or discourage bidding between the business office clerical and service and maintenance positions; however, even where hospital-wide posting of vacancies is required and employees use their seniority to bid, there is little crossover between service and maintenance employees and business office clericals (WS Shea at 18; WS Roitman at 1.)

7. *History of representation*. The appropriateness of separate business office clerical units is supported by a history of representation separate from service and maintenance employees. For example, at 250 hospitals surveyed by SEIU, business office clericals sought representation in 71 hospitals, of which 46 were separately organized, compared with service employees who organized in 195; a survey conducted by NUHHCE of 200 post-1974 elections in 100-plus bed hospitals showed 37 involved business office clericals, of which 33 were separate units (WS Shea at 15-16; Muehlenkamp, 4767-70). There are 92 separate business office clerical units represented by AFL affiliates in private sector hospitals. (AFL Br. App. A). Local 1199 had no combined non-professional units until *St. Francis II* (Friedman, 5035-41). Although there are business office clericals represented in

combined service and maintenance units (Stickler, Chi I 23-31 giving examples), some combined units may have resulted from an effort to minimize delay or to comply with *St. Francis II* (AFL Br. 70). The weight of the evidence establishes that business office clericals predominantly have been separately represented.

8. *Bargaining interests*. While all employees have some similar bargaining concerns, i.e., wages, hours, and fringe benefits, business office clericals have a number of different interests, e.g., pay equity, performance monitoring, productivity standards, career mobility, automation, and VDT stress, as opposed to concerns of service employees such as job security, subcontracting, economic survival, supplies, shift rotations, infectious disease, injuries, and patient care (WS Nussbaum at 3; WS Lewis at 2; WS Holtz at 12-13; WS Barton at 1; AFL Br. 64-65).

Despite the differences, in some instances business office clericals have bargained jointly with other non-professional employees and contracts have covered both non-professional employees and business office clericals. In 1987, Mercy Hospital negotiated a contract which included over 50 classifications in one overall non-professional unit (AHA Br. attach. 15) (One classification included such jobs as accounting clerk and lab department secretary and both received identical wage rates and wage increases for the duration of the contract). See also Comment 162, AMI; Saporta, 5142; Comment 154, Michael Reese Hospital, for other examples. However, in some cases where business office clericals negotiated together with service employees and the resulting contract provided for identical terms and conditions of employment, wages and upgrade negotiations often

remained separate, and clericals had different bargaining representatives. In one instance incentive bonuses tied to receivables were offered only to business office clericals, and in others the contracts contained separate wage schedules for business office clericals. (WS Holtz at 10; WS McKenna at 3-4.) At Roosevelt Hospital, although the union bargained jointly for clericals, technicians, and service and maintenance employees, the clericals had their own bargaining delegates, contracts for business office clericals and service and maintenance employees were administered separately, and there was no interchange of delegates or exchange of grievance handling (Colbert, 5020-22.)

9. *Proliferation*. Contrary to our concern, as expressed in the NPR, there was no evidence adduced at the rulemaking hearings indicating that a separate unit of business office clericals will lead to the proliferation of bargaining units in the industry. The admonition against proliferation of units was directed toward problems that might be caused by having many separate bargaining units, i.e., substantial numbers of strikes interfering with the delivery of health care services, wage whipsawing, and jurisdictional disputes. There is no evidence that the existence of a separate unit of business office clericals would result in such problems. There were no examples of sympathy strikes by business office clericals in support of service and maintenance employees, and no examples of leapfrogging because of a separate business office clerical unit. (WS Wynn at 3.) In one hospital as to which there was testimony about separate units, there was no evidence of jurisdictional disputes. (WS Gray at 4; Michael Reese Hospital). One argument advanced was that

because a business office clerical unit will not include all clerical classifications, e.g., ward clerks, there is a potential for conflicts between clerical groups. There was no evidence of specific examples, and we accord no weight to the theoretical possibility of a conflict.

10. *Legal Precedent*. Legal precedent supports finding separate business office clerical units appropriate. The Board has recognized the appropriateness of separate business office clerical units in every other industry covered by the Act, and until *St. Francis II*, in the health care industry. See e.g., *Armour & Co.*, 15 NLRB 268 (1939); *Legal Services for the Elderly Poor*, 236 NLRB 485 (1978); and cases cited in AFL Br. pp. 71-72. From 1974-1984, the Board did not find any business office clerical unit to be inappropriate (See NLRB Exh. 5, revised). Moreover, Senator Taft's industry-sponsored bill would have explicitly provided for separate office clerical units.

In *Baker Hospital*, 279 NLRB No. 38 (Apr. 16, 1986), the Board required the inclusion of business office clericals in a unit of service and maintenance employees. In so doing, the Board found that business office clericals and service and maintenance employees received the same fringe benefits and were covered by the same personnel, salary, promotion, seniority, transfer, and disciplinary policies. The Board also found that there was a significant amount of contact between clericals and unit employees. The Board held, therefore, that there was an insufficient disparity of interests between business office clericals and service and maintenance employees to justify excluding the clericals from the unit. After considering the substantial empirical evidence adduced in the rulemaking proceeding, we find it unlikely that we would reac' the same

result. The evidence from the hearings shows that business office clericals constitute a distinct group of employees. They perform substantially different functions, have a greater degree of education and training, utilize different skills, are separately supervised, receive higher wages, have a number of distinct bargaining interests, have little or no interaction with other employees, and frequently are located in geographically separate offices.

11. *Identification of business office clericals.* The evidence from the hearings indicates that there may be other clericals, e.g., ward clericals, medical records clericals, physicians' secretaries, and admitting office clericals who perform functions similar to those performed both by service employees and business office clericals or else perform a combination of functions such that they cannot be readily classified as one or the other. To date, however, the Board has decided the placement of these categories of employees on a case-by-case basis, generally excluding these classifications of employees from business office clerical units. See *Mercy Hospital of Sacramento*, 217 NLRB 765 (1975). There, the Board found a separate unit of business office clericals appropriate, and placed ward clericals in another unit because their work was more closely related to the function performed by personnel in the service and maintenance unit. The precise placement of particular classifications which may be disputed in a particular case is, for the time being, left to the case-by-case adjudicative approach.

C. Conclusion

Business office clericals share some terms and conditions of employment with all other service and maintenance employees, have occasionally participated in joint

bargaining, and may even have been covered by the same contracts. However, we are more persuaded by the evidence developed at the hearing as to their separate supervision, their different and specialized skills and education, their minimal interchange and contact, their different career paths and job markets, their maintenance of a separate identity even where bargaining was in a larger group, and, finally, the recent development whereby more and more business office clericals are being moved out of the hospital to different buildings or facilities. We believe that the weight of the evidence strongly supports finding separate business office clerical units appropriate.

XI. Other Non-Professionals

Based on our analysis of the evidence adduced, we have found appropriate separate units of technicals, business office clericals, and skilled maintenance employees. All remaining service and non-professional employees[24] shall, therefore, constitute a separate appropriate unit, where requested.

XII. One Hundred Bed Distinction

The proposed rule suggested establishing a different unit configuration for hospitals over 100 beds than for those of 100 beds or fewer based on the Board's belief that hospital size (as determined by the number of beds) was correlated with integration of labor, and that smaller

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[24] Excepting guards, of course, who must be placed in a separate bargaining unit. See section 9(b)(3) of the Act.

hospitals were more functionally integrated than larger hospitals, and could function with fewer, broader units. However, the record does not support that belief, and the Board has concluded that its rule regarding units in acute care hospitals should apply regardless of hospital size.

The vast majority of representatives of both unions and employers appeared to agree that hospital size is not well correlated with integration or division of labor, and opposed a rule differentiating between large and small hospitals. Examples of unions opposing the distinction were: AFL Br. 139-140; ANA 4919-20; SEIU, 5215; Hospital Professionals and Allied Employees of New Jersey, 125. Over 40 employers registered specific or general criticism of use of a 100-bed distinction, including AHA, Br. 48; League of Voluntary Hospitals, 226-229, 254; Hospital Council of Western Pennsylvania, 4395; Comment 5, Holy Redeemer Health Systems; Comment 15, Methodist Health Systems; Comment 25, Bradley Memorial Hospital; Comment 78, Greater Cincinnati Hospital Council; Comment 82, Humana, Inc.; Comment 104, St. Francis Hospital. Experts in the field agreed with the parties' position (Rosen, 4663; McKinney, 5519-20). Only a handful of commentators supported the use of any distinction based on the number of beds. For example, Comment 11, National Rehabilitation Hospital; Comment 105, Mass. Hosp. Assn.

A survey by UFCW comparing the number of beds and the staffing in hospitals of varying sizes in five states showed a wide variation in staff size (UFCW Exh. 6-11). For example, in New York State, among 46 hospitals surveyed with 20-100 beds, one hospital with 20 beds had over 200 employees, one with 21 beds had 50 employees,

one with 20 beds had 209 employees, while another with 129 beds had 181 employees. (UFCW Exh. 11). In California, one hospital with 107 beds had 1011 employees, while another with 110 beds had 299 (UFCW Exh. 6). In Illinois, hospitals with 77 and 91 beds had 279 and 429 employees, respectively, while another hospital with 129 beds had 126 employees (UFCW Exhs. 5, 6). Similar variations, and lack of correlation, appeared throughout the exhibits.

Lack of correlation between number of beds and number of employees may be attributable to specialization or the amount of outpatient services (UFCW Exh. 1-11; WS Willman & 4500; Rosen, 4663; AFL Exh. 20). Thus, it appears that staffing size and patterns might correlate more closely with the nature of services than with bed number (AHA Br. 47; New Jersey Society for Health Care Human Resources Administrators, 439).

The AHA correctly noted that the Board's proposal for a 100-bed distinction did not clarify how it defined the term "bed" (AHA Br. 47). The record shows that there are several meanings of the term in health care facilities. A bed may be licensed or unlicensed; if licensed a bed may be occupied or unoccupied (AHA Br. 47; Comment 52, Hillcrest Baptist Medical Center). Hospitals may change the number of licensed beds more than once a year (California Association of Hospitals and Health Systems, 3229). Occupancy rates vary; a hospital may have occupancy substantially below the number of its licensed beds (Comment 1, Lancaster Fairfield Hospital; Comment 115, National Healthcare, Inc.: rural areas may have only 25-30% patient census). The number of staffed beds (based on average projected occupied beds and patient

acuity) can differ from the number of occupied beds (Comment 186, Hiawatha Community Hospital; Comment 191, Trinity Lutheran Hospital.) Beds may also include swing beds (beds that swing between acute care and nursing or long-term care) (Missouri Hosp. Assn., Chi II 265).

The Board also notes that to the extent unions and employers addressed the standard to be used if the Board determined to have a bed-number distinction, they rejected the use of 100 beds as an appropriate bed measure but did not reach a consensus as to the appropriate number of beds to use. For example, some unions suggested using the definition of small hospitals employed by the U.S. Department of Health and Human Services in calculating reimbursements under Medicare, which is those hospitals with fewer than 50 licensed beds. (AFL Br. 141; WS Sweeney.) The AHA suggested a 400-bed cutoff (AHA Br. 141), but other employers suggested 250 beds (Comment 169, Columbus Hospital); 300 beds (Comment 126, Arlington Memorial Hospital); 450-500 beds (Comment 1, Lancaster Fairfield Hospital); and 500 beds (Comment 11, National Rehabilitation Hospital).

The Board's decision to drop the 100-bed distinction is based on the evidence provided by the parties regarding the lack of correlation between bed number and hospital staff, the multiplicity of definitions for the term "bed" in health care, the lack of consensus on the number of beds dividing large and small hospitals, and the

parties' general opposition to use of a distinction based on the number of beds.[25]

XIII. Nursing Homes

The only health care facility, other than hospitals, covered by our proposed rule was nursing homes. In so doing, we tentatively determined that the appropriate bargaining units for this type of health care facility should be the same as that for small hospitals, i.e., (1) all professionals, (2) all technicals, (3) all service, maintenance, and clericals, and (4) all guards. After careful consideration of all the evidence presented at the hearings, however, we have concluded that the rule should not apply to nursing homes.

To a larger extent than acute care hospitals, nursing homes vary both in size and type of service rendered. Generally speaking, there are three basic types of nursing home facilities: skilled nursing, intermediate care, and residential care. Skilled nursing homes provide 24-hour inpatient nursing care to chronically ill or stable convalescent patients, are state licensed, and are eligible for both Medicare and Medicaid. Intermediate care facilities also provide 24-hour inpatient care, but care is less intensive and more oriented to daily living. These homes are also state licensed or certified but are eligible only for

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[25] We note, parenthetically, that the information we have acquired as to the relationship between staffing and number of beds most likely would not have been acquired in an adjudicatory proceeding, and provides further evidence of the value of rulemaking in obtaining industry-wide information unavailable in a case-by-case approach.

Medicaid. Residential care facilities meet only social needs, not medical, and are not licensed. (Durham, 3164-66, 69, 71, 83; Comment 155, Indiana Healthcare Assn. (IHA).) The facilities range in size from 10-500 patients (Harris, 4294; Comment 284, Ryan). One-third have a capacity for fewer than 50 residents, one-third for 50-99, and one-third for over 100 (Harris, 4304).

Unlike hospitals, nursing homes are populated primarily by the elderly and provide long-term care rather than medical treatment of a specific illness. Consequently, nursing home staff are concerned not only with their residents' physical well-being but also their social and psychological needs. Accordingly, there is less diversity in nursing homes among professional, technical and service employees, and the staff is more functionally integrated. (Harris, 4294-95; Willman, 4501-02.) Generally, nurses provide a less intensive, lower level of care to patients in skilled and extended care facilities, and thus receive lower salaries than that paid in acute care hospitals (AHA Br. 6-7 citing *Modern Healthcare*, Jan. 3, 1986). In addition, RNs in most nursing homes never administer oxygen or assist in surgery, and therefore generally have no interest in or need for acute care pay differentials or for specialization (Comment 155, IHA; Shepard, 4962). Also, there is for the most part little difference in the duties of LPNs and nurses' aides (Comment 155, IHA). Both are primarily responsible for providing nursing care to patients (Comment 155, IHA, affidavits of Miller and Price; AHA Br. 6 citing *Modern Healthcare*, Jan. 3, 1986). Indeed, almost no aspect of nursing home care is in the exclusive domain of any one group of employees (Harris, 4295). Thus, there appears to be a greater overlap of

functions as well as greater work contact between the various nursing home non-professionals (Willman, 4501-02; Comment 155, IHA, affidavits of Townsend and Turner-Simpson).

Skilled care homes also differ from hospitals in that a ratio of 50 patients per nurses' station is ideal for nursing homes, whereas the typical ratio for acute care units is half that number (AHA Br. 7 citing *Modern Healthcare*, Jan. 3, 1966).

Also unlike hospitals, there are few professionals employed at nursing homes, and of those, most are RNs who serve as head nurses or charge nurses primarily performing administrative duties (Durham, 3190; Willman, 4501-02; Saporta, 5145-46; Bullough, 4656-57; Comment 155, IHA, affidavits of Davy, Townsend, Turner-Simpson, and Higdon). There are also few business office clericals. In a typical 100-bed nursing home, the business office will have one or two employees. In a 100-bed acute care hospital, the office consists of payroll employees, accounts receivable and payable employees, data processing employees, and others. (Comment 155, IHA).

Greater differences in the size and purpose of nursing homes have resulted in greater differences in their organization, regulation, and staffing patterns. For example, in very large homes, business office clericals may be physically separated from the home, and have little employee or patient contact. In very small homes, the business office is located next to the patient care areas and there is continuous contact with the patient care staff. (Comment 155, IHA; Durham, 3166-67). Duties of staff also vary with the size of the institution. In a small, 10-

resident facility, the staff will have overlapping responsibilities, and thus an overall unit would be appropriate. In a large, skilled care facility with specialized units (see *infra*), more than one unit might be appropriate (Harris, 4298). In an intermediate care facility which also cares for the mentally disabled as a result of trauma, there may be a separate group of employees, such as psychiatrists, who have distinct supervision and little contact with other professionals (Durham, 3170).

Although most homes are regulated by the state, regulations with respect to staffing patterns and employee qualifications vary widely from state to state (Harris, 4296-97; Comment 284, Ryan). For example, Connecticut requires more skilled nursing care than Iowa, and in some states, skilled nursing facilities must have 24-hour RN coverage. Seventeen states have mandated nurses aide training programs ranging from 20 hours to over 100 hours. A majority of states have no specific training requirements. In Massachusetts, the activity director and the social service director must have baccalaureate degrees; in other states, their formal qualifications are less than those of a nurses' aid. (Harris, 4297; Comment 284, Ryan; Comment 155, IHA.) Also in Massachusetts, as in other states, homes must be staffed by LPNs or RNs, and they are required to provide substantial direct patient care. In contrast, in Indiana, with lesser staffing requirements, nurses' aides provide direct patient care, and LPNs perform RN-type duties such as distributing medication and assisting doctors. (Comment 155, IHA.)

The nursing home industry is also in a period of rapid transition. It is currently undergoing enormous

growth as the population of older persons increases and family responsibility for older parents lessens. In addition, many long-term facilities will increasingly offer non-traditional specialized services, i.e., head and spinal cord injury units, intensive rehabilitation, sub acute care, Alzheimers, respiratory therapy, hospice care, nutrition, AIDS, home health care, and care for ventilator dependent patients. (Harris, 4299; Comment 284, Ryan; Durham, 3161; AHA Br. 6 citing *Modern Healthcare*, Jan. 3, 1986.) These services require different staffing needs. For example, in most Alzheimers' units, nurses' aides receive psychological training in order to respond properly to their patients' behavior, and LPNs are required to perform recreational, educational, and social activities that are normally done by service employees such as recreational aides. A head injury unit requires many more professionals than are usually present in a nursing home facility. An AIDS facility might need more counselors. (Harris, 4300-4301; Comment 284, Ryan.) The professional and technical staff in a specialized service area such as a coma unit may also be far more integrated than RNs and LPNs who work in the nursing area (Comment 306, Harris).

For some or all of the reasons discussed above, numerous witnesses were opposed to applying the rule to nursing homes (Durham, 3179; Harris, 4293-94; Comment 284, Ryan; Comment 155, IHA; Comment 155, IHA, affidavit of Miller; Comment 3, Jefferson Davis Nursing Home). Three witnesses would support a two-unit approach (Comment 22, Louisiana Nursing Home Assn.; Comment 27, Jefferson Manor Nursing Home; Comment

34, Lewisburg United Methodist Homes). Several commentators thought the Board lacked sufficient experience with respect to nursing homes to formulate a rule as to such facilities (IUOE Br. 2, fn 1; Durham, 3179; Harris, 4304). Board statistics show that only 20% of the elections in the health care industry have involved long-term care facilities (Harris, 4302). Also, case-by-case determinations of appropriate units in nursing homes have not caused undue litigation (Comment 155, IHA). In fact, to the best of our knowledge there is not a single published case since the health care amendments in which the Board had to decide appropriate units in nursing homes, and no party testified that it had experienced problems with case-by-case determinations as to this issue.

In view of the evidence set forth above, we have decided to exclude nursing homes from the rule. The evidence shows that there are not only substantial differences between nursing homes and hospitals but also significant differences between the various types of nursing homes which affect staffing patterns and duties. In the absence of a measure of uniformity of operation, it would be difficult to establish uniform rules with respect to appropriate bargaining units. It also appears that there is no need at this time for a rule with respect to nursing homes as there has been no prolonged litigation and no party has expressed any problems in this area. We, therefore, conclude that it is best to continue a case-by-case approach with respect to nursing homes. For those facilities which provide both hospital and nursing home services, if the facility is primarily an acute care hospital, it will be treated in its entirety as a hospital; if primarily a nursing home, it will be considered a home, and outside

the rule. To do otherwise would further fractionalize bargaining within the facility, and cause more, rather than less, proliferation.

XIV. Specialized Hospitals

Some employers suggested that the Board make a separate rule for specialty hospitals, arguing that they are neither acute care hospitals nor nursing homes (Comment 172, New England Sinai Hospital; King, 4230-31). The evidence with regard to most of the specialty hospitals which participated in the rulemaking did not support a conclusion that there are fewer traditional distinctions between employee groups. However, the evidence demonstrated that psychiatric hospitals, are, for a number of reasons, in a category apart, and the Board has decided to exclude psychiatric hospitals from application of the rule.

Initially, the industry's claimed trend toward one-specialty hospitals is not supported by statistics. The AHA classifies 90% of U.S. private, acute care hospitals as general; of these, 98% are general medical and surgical hospitals and only 2% are pediatric or rehabilitation hospitals. Nine of the remaining ten percent are psychiatric, a category apart (AFL Exh. 7,8.) In California, where the industry contends the trend is particularly strong (Dauner, 3206), there are relatively few specialized hospitals (Silberman, 3209-12).

Most of the comments submitted to the Board from specialty hospitals apart from psychiatric hospitals did not argue that these hospitals should be treated differently from general acute care hospitals. See for example,

Comment 4, Le Bonheur Children's Medical Center, Comment 10, National Rehabilitation Hosp.; Comment 123, Children's Memorial Hosp.; and Comment 303, Children's Medical Center, Akron, regarding childrens' hospitals. Although Children's Medical Center of Dallas (Comment 276) states that in that hospital RNs integrate patient care with some other professionals, and Cardinal Glennon Children's Hospital (Comment 271) discusses use of the team approach, neither suggests that childrens' hospitals differ from general acute care hospitals for purposes of rulemaking. While Shriners Hospitals For Crippled Children (Comment 238) were unique in their method of obtaining funds and charging patients, they operate like other acute care hospitals, subscribing to the same rules of licensure and accreditation.

Two hospitals, Children's Hospital of Dayton and Children's Hospital of Cincinnati presented more details regarding the operation of childrens' hospitals (Testimony of Graybill, Sokatch; Comment 288, Graybill). There is evidence that childrens' hospitals have higher acuity and outpatient activities than general acute care hospitals, and as a result have more full time equivalent positions and higher budgets than comparably sized general acute care hospitals (Comment 288). There is also evidence that RNs have a somewhat higher level of interaction with other professionals, for example, interacting with respiratory therapists on ICU units and transports (Graybill, 4183), working on special teams like bone marrow transplants, interacting with pharmacists regarding allergies, and tube sequencing (Comment 288). Even assuming that respiratory therapists are professionals, a status the Board has rejected on some occasions, (see for

example, *Samaritan Health Services*, 238 NLRB 629, 638 (1978)), the interaction of RNs with other professionals, including presence on teams, is similar to that shown in other hospitals, and RNs' duties were not shown to be different merely because they may work on teams. As in other acute care hospitals, most nurses in childrens' hospitals are directly or indirectly supervised by other nurses (Graybill, 4147-48, 4164).

Comments from rehabilitation hospitals show similar arguments to those made by general acute care hospitals: that there is increased contact between RNs and other professionals, that there is some cross-training and utilization, that teams are used, that a hospital has across-the-board personnel policies (Comment 172, New England Sinai Hospital; Comment 131, The Institute for Rehabilitation and Research). These commentators did not request special treatment for their hospitals. Of course, to the extent rehabilitation hospitals may be long term, they will not fall within the parameters of the Board's rule, *infra*, which applies only to hospitals whose average patient stay is less than 30 days.

Nor was there a suggestion made by commentators of other, non-psychiatric, single specialty hospitals that their type of hospital merited special rules. For example, the Board received evidence from Springfield General Hospital (Comment 201) and Oklahoma Osteopathic Hospital (Comment 300), both osteopathic hospitals, in opposition to the rulemaking, but not claiming a special status for specialty hospitals.

As noted above, the evidence received on psychiatric hospitals supports an exception for this specialty. Psychiatric hospitals constitute a substantial portion (9%) of

private hospitals in the U.S. (AFL Exh. 7). Even the AFL, the only union which took a position on psychiatric hospitals, provided a mixed case for including these hospitals under the rule. Thus, while the AFL argued that psychiatric hospitals which provide short term care are acute care hospitals, it recognized that there is evidence to suggest that at least some professionals play different roles in psychiatric hospitals than in acute care hospitals (citing Albanese/Caswell, Chi I 148-165). Further, the AFL noted that the Board has treated psychiatric facilities differently from other hospitals. Thus, *Mt. Airy Psychiatric Center*, 253 NLRB 1003 (1981), was the only pre *St. Francis II* case in which the Board refused to find appropriate a separate RN unit. Finally, even the AFL acknowledged that the Board might wish to exclude exclusively psychiatric facilities from the rule. (AFL Br. 140, fn.).

The two main industry representatives who presented evidence on psychiatric hospitals strongly urged that psychiatric hospitals not be considered acute care hospitals for purposes of rulemaking. Most of the evidence submitted with regard to psychiatric hospitals came from the National Association of Private Psychiatric Hospitals (Comment 307, Thomas) and from Charter Medical Corporation (Albanese/Caswell, Chi I 148-165). The National Association represents a substantial majority of private psychiatric hospitals in the U.S. Charter Medical represents about 60 psychiatric hospitals. Therefore, the Board considers their evidence to be representative of psychiatric hospitals in general. The other employers representing psychiatric hospitals agree that psychiatric hospitals operate in a distinct manner (Comment 110, Charter Lakeside Hosp.; Comment 35,

Massachusetts Chapter of the National Association; Comment 29, Glen Eden Hospital; Comment 120, HCA Belle Park Hospital; Comment 168, Camelback Hospitals; Comment 298, Palo Verde Hospital).

The evidence showed that unlike other acute care hospitals, psychiatric hospitals do not provide patient care for the physically ill. RNs are not the primary facilitators of health care in psychiatric hospitals. Many professionals participate hands-on with patients. Regardless of which of three basic models a psychiatric hospital follows: medical, milieu, or combined, the programs are highly integrated. RNs' work is closely integrated with the work of clinical psychologists, counselors, social workers, and various types of therapists in a treatment plan as designated by doctors and program coordinators.

There are more professionals other than doctors and RNs in psychiatric facilities than in other acute care facilities. The ratio of RNs to other professionals is about 1:1 regardless of facility size. It appears that non-RN professionals would not have the same concerns about being outnumbered in an all-professional unit as they have expressed regarding organization in acute care hospitals.

Psychiatric hospitals also differ from other acute care hospitals in that there are more paraprofessionals (mental health workers), and all employees are specially trained in relating to the patients as all employees' actions have an impact on patient treatment.

Further, the evidence shows that Congress has distinguished between acute care general and psychiatric hospitals under Medicare by setting special Medicare

certification requirements with respect to staffing, treatment planning, teams, etc.

For all these reasons, the Board has decided to exclude "primarily" psychiatric hospitals from its rule for units in acute care hospitals and to proceed as to them on a case-by-case basis. A number of acute care hospitals have psychiatric sections, however, and such hospitals are not thereby excluded from application of the rule unless the psychiatric sections predominate. Nor do we adopt the suggestion of the AFL that the exclusion be limited to hospitals that are "exclusively" psychiatric, as we deem such an exclusion to be too limited. See the definition of "psychiatric hospital" contained in 42 U.S.C. 1395 x (f).

XV. Partially Organized Facilities

In the first Notice of Proposed Rulemaking, we limited the applicability of the rule to petitions for initial organization, and commented that "historically the Board has required decertification petitions to be filed in the certified or recognized unit." (52 FR at 25145). By way of further explanation, the Board added that "when institutions are partially organized we assume that petitions for new units will follow the proposed rules, insofar as possible." (*Id.*)

As indicated *infra*, in Sec. XIX, Combined Units, the principle of *Cambell Soup Co.*, 111 NLRB 234 (1955), will continue to apply to decertification petitions. See also *Westinghouse Electric Corp.*, 115 NLRB 530 (1956). With respect to other types of petitions in partially organized facilities, we wish to amplify our previous remarks.

In the Second Notice of Proposed Rulemaking, "insofar as practicable" language [changed from "insofar as possible"] is now part of the proposed rule. However, there are two different possible situations we can envisage:

(1) Where existing units are in conformity with the new proposed final rule, we can foresee no reason that new petitions, for the same or other units, should not also be in conformity with the new rule.

(2) Where existing units are not in conformity with the new proposed final rule, we can anticipate a number of questions arising with respect to the applicability of the new rules. Where units smaller than those permitted by the rules already exist, may the incumbent petition for a residual unit? May another labor organization? What will be the continued viability of the principles enunciated in *Levine Hospital of Hayward*, 219 NLRB 327 (1975)? In Comment 304, Kaiser Permanente raised a number of these questions, claiming that "many health care employers, including Kaiser Permanente, currently have bargaining relationships with unions in units that are narrower than those set forth in the proposed rules." These issues have not been extensively addressed during the rulemaking proceeding, and it is the Board's judgment that their resolution should, for the time being, be deferred pending the adjudication of particular cases that present these issues. The Board will, in the adjudication of cases, attempt to apply the new rules to these situations insofar as practicable.

XVI. Facilities Covered

The Board stated in its proposed rule that the rule would apply to acute care hospitals, but did not define the term. Noting the concern of some commentators during the Board hearings with the absence of a specific definition, the Board has carefully reviewed a variety of sources in order to reach a definition. In particular, the Board has extensively searched Federal health care legislation, agency regulations, legislative history, industry reference materials, and hearing testimony for an authoritatively based and commonly understood distinction suitable to the goals of rulemaking in the health care industry. Research reveals that there is a commonly understood distinction between acute and long term care facilities, but that the terms are not statutorily defined as such.

The Public Health Service, for example, draws a distinction between acute care and long term care facilities for the purpose of administering special projects and grants (42 U.S.C.S. 296k(a) (4) and (7) (1985)), and for administering grants to nurse practitioners and midwife programs (42 U.S.C.S. 296m(a)(2)(A) (1985)). Various sections of the Social Security Act make the same distinction: e.g., for purposes of determining the scope of review of peer group organizations (42 U.S.C.S. 1320c-3(a)(4)(A) (1986)), and for determining the application of payment in accordance with state reimbursement control systems (42 U.S.C.S. 1395ww(c)(1)(A) (1983)). Despite the repeated use of the terms acute care and long term care, however, no statutory definition is provided.

In regulations promulgated by the Department of Health and Human Services, the agency principally responsible for administering health care legislation, there is also a distinction between acute and non-acute care facilities. The term "like [similar] hospital", for example, is used in reference to the special treatment given sole community hospitals and is defined as a "hospital furnishing short-term, acute care." (42 CFR 412.92(c)(2) (1987)).

Finally, a review of the extensive legislative proceedings surrounding health care legislation and related issues likewise reveals regular use of the acute care/long term care distinction, with the terms "short term hospital" and "acute care hospital" used interchangeably. Here again, though, the use of these terms is so commonplace that no specific definition is provided.

In light of this commonplace usage, but lack of statutory or legislative definition, the Board has adopted the definition of an "acute care hospital" provided by the Dictionary of Health Services Management, edited by Thomas Timmreck, Ph.D., 1982, National Health Publishing, Owings Mills, Maryland.

The Dictionary of Health Services Management defines an "acute care hospital" as a short term care hospital with an average length of patient stay of less than 30 days. This definition was also referred to with apparent approval by the AFL in this proceeding and is used by the American Hospital Association (AFL Exh. 20, AHA Guide to the Health Care Field, 1987).

The definition of a "psychiatric hospital" for the purposes of this rule shall be that set forth in 42 U.S.C.

1395x(f). According to that definition, a psychiatric hospital is an institution which:

> (1) Is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;
>
> (2) Satisfies the requirements of paragraphs (3) through (9) in the definition of a "hospital" in that statute [§ 1395x(e)];
>
> (3) Maintains clinical records on all patients; and
>
> (4) Meets certain staffing requirements found necessary by the Secretary.

Coverage for the purpose of this rule, then, will include all acute care hospitals as defined. A hospital is covered if its primary service is acute care, regardless of the presence of other non-acute care units at the same facility. Psychiatric hospitals, defined above and dealt with in section XIV, are specifically excluded from coverage. Also excluded are nursing homes.

As previously indicated, rehabilitation and drug-alcohol hospitals that meet the 30-day standard are tentatively included as the Board did not receive sufficient information during the proceedings to distinguish these facilities for the purposes of this rulemaking.

XVII. Decisions To Which Rule Applies

The NPR suggested that the Board's new health care rule would be effective "on a prospective basis only, for petitions filed on and after (30 days after publication of the final rule)." In *St. Vincent Hospital and Health Center,*

285 NLRB No. 64 (Aug 19, 1987), the Board indicated that while its proposed rulemaking procedure was pending, it would continue to make unit determinations in health care cases on a case-by-case basis utilizing the criteria set forth in *St. Francis Hospital,* 271 NLRB 948 (1984) (*"St. Francis II"*). The Board also reiterated that it would apply its new rule prospectively only to cases in which petitions were filed after the rule became effective. Based on comments received in the record, and upon further consideration, the Board has concluded that its rule regarding appropriate units in the health care industry shall apply to all decisions made on and after the effective date of the rule.

Representatives of unions urged the Board to revise the proposed prospective application of the new rule. One union suggested that the rule should be effective for all cases decided after the rule was published, even if the petition was filed prior to that date (ANA Br. 197). Unions suggested that it would be unsound, if not arbitrary, to disregard the rule in pending cases, considering the vast body of knowledge the Board now possessed by virtue of its rulemaking proceedings (ANA Br. 196, AFL Br. 145-146). The AFL asserted that to apply preexisting law would deny employees the right of self organization. The AFL noted that applying the rule retroactively would not have an ill effect on pending representation cases. The AFL also noted that the Board recently gave retroactive application to its decision in *John Deklewa & Sons,* 282 NLRB No 184 (Feb. 20, 1987), enfd. *sub nom Iron Workers Local 3 v. NLRB,* 843 F.2d 770 (3d Cir. 1988). Further, the AHA and AFL noted that the Board applied its *St. Francis II* decision retroactively, and remanded many bargaining

unit cases to regional directors for further consideration. (AHA Br. 203-204; AFL Br. 145.) ANA also noted the incongruity that could result if the Board enacted a rule that conflicted with pre-rule standards, e.g., finding a unit inappropriate that previously was appropriate. (ANA Br. 204 at n.115.)

The Board has decided that its rule on appropriate bargaining units in the health care industry should be applied to all decisions made on and after the effective date of the rule, which will be 30 days after publication of the final rule in the Federal Register. See APA, 5 U.S.C. 553(d). The Board agrees that it would be incongruous to apply the rule as originally stated; that is, only to petitions filed 30 days after publication. Such a rule would arbitrarily affect petitions filed just 1 or 29 days after the rule is published, and could conceivably lead to vastly different results based solely on the timing of the petition. However, the Board will apply its pre-rule standards to cases that issue prior to the effective date of the rule. As we indicated in *St. Vincent*, we deem it unwise either to decline to take any action on pending petitions, or to promulgate a new standard while rulemaking proceedings are pending. We continue to deem it contrary to statutory policy to hold cases pending effectuation of the Board's new rule. Accordingly all cases that issue prior to the effective date of the rule will be analyzed under *St. Vincent*. If cases currently pending before the Board do not issue prior to the rule's effective date, the Board will not apply the rule *de novo* to such cases. Rather, the Board will, where necessary, remand such pending cases to regional directors to determine the need for a hearing or

other appropriate course of conduct in order to permit parties to address the rule.

XVIII. Non-Conforming Stipulations

In the initial proposed rule, the Board stated that it would approve consent agreements providing for elections in accordance with the units set forth in the rule, and that no other agreements would be approved. Several commentators urged the Board to permit stipulated units even when they do not comport with those specified in the rule. We have been persuaded that permitting non-conforming stipulations, which are not prohibited by the Act, may, in many instances, better serve the interests of the parties, and perhaps even the Board. The Board therefore has tentatively decided to allow its regional directors to approve stipulations providing for elections in units not provided for in the rules.

It is the Board's established practice in other areas to permit parties to stipulate to the appropriateness of units and to various inclusions and exclusions if the agreement does not violate any express statutory provision or established Board policies. See, e.g., *SCM Corporation*, 270 NLRB 885, 886 (1984). This policy on stipulated units was extended to the health care industry in *Otis Hospital*, 219 NLRB 164 (1975). The Board there reasoned that it is consonant with the design of the Act to give the parties in representation proceedings the broadest permissible latitude to mutually define the appropriate unit. The Board stated that when the parties' perceptions coincide regarding unit appropriateness, in the absence of a statutory command or policy considerations within the Board's

expertise, the Board is not the better judge. The Board noted in *Otis Hospital* that the legislative history of the 1974 health care amendments supports the application of general policy regarding stipulated units to the health care industry.

Our expertise acquired throughout this rulemaking proceeding gives us considerable pause with regard to stipulations not in accordance with our proposed rules. Thus, stipulations in conformity with these rules would surely be preferable. However, we recognize the possibility that the parties have their own reasons for preferring to bargain in some other configuration. Moreover, we note that the majority of certifications issued in representation cases in the health care industry following enactment of the amendments followed either a consent or stipulated election and that these elections gave rise to challenges less often than directed elections. Annual Reports of the National Labor Relations Board, Tables 9, 11B. In view of Congress' concern with stability in health care labor relations, the importance of reducing unnecessary litigation, and expeditiously proceeding with elections, permitting stipulations, even when they do not conform to the Board's explicitly drawn units, seems warranted. For these reasons, we have decided that the reasoning of *Otis Hospital* should remain applicable despite this rulemaking proceeding.

To the extent a stipulation may later result in the creation of a residual group of unrepresented employees, the Board will address their representation concerns as it would those of other groups of residual employees present in partially organized acute care hospitals – on a case-by-case basis applying the rules insofar as practicable.

Despite our tentative decision to accept non-conforming stipulations, we expressly invite any interested party to comment further on this problem during the period provided for comments.

XIX. Combined Units

The Notice of Proposed Rulemaking provided that, in addition to the specified units, "any combination will also be appropriate, at the union's option and so long as the requirements of section 9(b) (1) and (3) are met." The reason for the reference to the union's option was that the union, as petitioner,[26] need seek only an appropriate unit. *Morand Brothers Beverage Co.*, 91 NLRB 409, 417-18, enfd. on other grounds 190 F.2d 576 (7th Cir. 1951); *Parsons Investment Co.*, 152 NLRB 192, 193 at fn. 1 (1966). It does not benefit an employer to have the option of showing that another unit, perhaps a combined unit, is also appropriate, or even more appropriate, since the appropriateness of an alternative unit is not the issue. *Parsons Investment Company, supra; Federal Electric Corporation*, 157 NLRB 1130, 1131-32 (1966). We therefore reject arguments by some employers that it is unfair to give only unions the option of combining units. (See, e.g., AHA Br. 49; Comment 258, Durham, attorney for California Association of Health Facilities.)

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[26] If the employer is the petitioner (RM petition), its petition must seek the unit requested by the union. *Wm. Wood Bakery*, 97 NLRB 122 (1951); *Restaurant & Tavern Owners Association of Salem*, 126 NLRB 671 (1960). If the petition seeks decertification, it must be filed in the certified or recognized unit. *Campbell Soup Co.*, 111 NLRB 234 (1955).

However, upon reflection, we believe that we defined too broadly a union's option to seek, alternatively, combined units. In the NPR, as indicated, we implied that *any* combination of the enumerated units would also be appropriate; after giving this matter further thought, we believe that we have insufficient evidence at this time to say that, *per se*, all combinations will be found appropriate. We believe this is a matter we will have to decide in the course of individual cases, by adjudication. While there are some combinations that, while not required under these rules, would obviously be appropriate, such as all professionals, or all non-professionals, there may be other, more unusual combinations that need to be examined for appropriateness. We meant to say only that combinations of the enumerated units are not thereby precluded, and we have therefore modified the rule to provide that combinations "may" be appropriate.

XX. Extraordinary Circumstances Exception

The Board has, in order to ensure satisfaction of parties' due process rights,[27] included in both the proposed rule and the final rule an exception for "extraordinary circumstances." The exception has been provided to

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[27] See *Chemical Manufacturers Assn. v. Natural Resources Defense Council*, 470 U.S. 116, 133 n. 25 (1985); *Heckler v. Campbell*, 461 U.S. 458, 467 (1962); *FPC v. Texaco, Inc.*, 377 U.S. 33, 40 (1964); *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956); *National Broadcasting Company v. United States*, 319 U.S. 190, 225 (1943); *WAIT Radio v. FCC*, 418 F.2d 1153, 1157 (D.C. Cir. 1969); 1 C Koch, *Administrative Law and Practice* § 4.112 at 321-23 (1985).

allow for the possibility of individual treatment of uniquely situated acute care hospitals, so as to avoid accidental or unjust application of the rule.[28] However, the Board wishes to emphasize that while the rule does not, therefore, conclusively establish invariable parameters of bargaining units in the industry, our intent is to construe the extraordinary circumstances exception narrowly, so that it does not provide an excuse, opportunity, or "loophole" for redundant or unnecessary litigation and the concomitant delay that would ensue. The Board has considered fully and at length all evidence presented and arguments submitted at the rulemaking hearings and during the comment period. None of the referred-to variations between acute care hospitals, some of which are enumerated below, are matters which would qualify for litigation under the special circumstances exception; rather, they are merely minor differences, inherent in the industry due to the multiformity of individual constituent institutions. The Board deems such variations to be ordinary, and hence by definition not extraordinary,[29] even in situations in which such variations may be highly unusual.[30]

Among the variations in acute care hospitals illustrated at the hearings and considered by the Board are

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[28] Cf. *National Nutritional Foods Assn. v. FDA*, 504 F.2d 761, 784 (2d Cir. 1974), cert. denied 420 U.S. 946 (1975), citing *The New England Divisions Case*, 261 U.S. 184, 204 (1923).

[29] See *Bollman v. Indianapolis Machinery Co.*, 150 Ind. App. 296, 276 N.E.2d 606, 613 (1971); *Black's Law Dictionary* 527 (rev. 5th ed. 1979), and cases cited therein.

[30] See *Kugler v. Helfant*, 421, U.S. 117, 125 (1975).

arguments relating to: (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nation-wide hospital "chains"; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building. Except as specifically noted elsewhere (e.g., exclusion of psychiatric hospitals and nursing homes from coverage by the rule), the Board has concluded that none of the arguments raised in the course of the rulemaking procedure, including those listed above,[31] alone or in combination, constitutes an "extraordinary circumstance" justifying an exception from the rule.

The Board is well aware that facilities will, and do, differ in some respects; however, as we observed in the NPR (52 FR 25144), it is the Board's considered judgment, after issuing health care decisions by adjudication for

[31] The arguments listed were selected by way of example and not by way of limitation, and were chosen merely as being illustrative of the Board's intent.

more than 13 years, that acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units.[32] Moreover, to the extent that the rulemaking hearings demonstrated that at least in some respects acute care hospitals do vary, the Board has made a judgment that, in this area of establishing appropriate units, "[d]etailed analyses of all the facts of the particular case are just not that enlightening,"[33] and that the policies of the Act would better be effectuated by the establishment of appropriate units in the enumerated segments of this industry by exercise of the Board's section 6 rulemaking authority.[34]

To satisfy the requirement of "extraordinary circumstances," a party would have to bear the "heavy burden" to demonstrate that "its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding,"[35] as, for instance, by

[32] See, e.g., NLRB Exhibit 5, revised, showing that for the 13 years since passage of the health care amendments, variations among facilities and their methods of operation had virtually no effect on the Board's ultimate decisions reached following frequently lengthy, case-by-case adjudications as to appropriate units.

[33] Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 105, 107 (1981).

[34] See *Cummins v. Schweiker*, 670 F.2d 81, 83 (7th Cir. 1982).

[35] *Basic Media, Ltd. v. FCC*, 559 F.2d 830, 834 (D.C. Cir. 1977). Accord, *P & R Temmer v. FCC*, 743 F.2d 919, 930 n.11 (D.C. Cir. 1964); *Industrial Broadcasting Co. v. FCC*, 437 F.2d 680, 683 (D.C. Cir. 1970). See also *WAIT Radio v. FCC*, 459 F.2d 1203, 1207 (D.C. Cir. 1972), cert. denied 409 U.S. 1027 (1972); *WAIT Radio v. FCC*, 418 F.2d 1153, 1157 (D.C. Cir. 1969).

showing the existence of such unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field, that it would be unjust[36] or an abuse of discretion[37] for the Board to apply the rules to the facility involved.

The Board, contrary to some industry representatives (e.g., Comment 148 Mississippi Hosp. Assn.), anticipates that litigation under the "extraordinary circumstances" exception will be rare; the AHA, representing the largest group of health care employers in this proceeding, has indicated it understands that the Board intends to limit exceptions to "truly extraordinary situations" (AHA Br. 55-56), and neither the AHA nor any other employer (or union) representative has raised objections to the Board's stated intent.

In most instances, should a facility claim it comes within the "extraordinary circumstances" exception, it should present an offer of proof to the Hearing Officer, who will then either permit the requested evidence to be adduced or, we anticipate far more commonly,[38] refer the offer to the Regional Director, and, if requested, ultimately to the Board, for ruling.

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[36] *National Nutritional Foods Assn. v. FDA*, 504 F.2d 761, 763 (2d Cir. 1974), cert. denied 420 U.S. 946 (1975).

[37] *P & R Temmer v. FCC*, 743 F.2d 919, 929 (D.C. Cir. 1984); *Ashland Exploration, Inc. v. FERC*, 631 F.2d 817, 823 (D.C. Cir. 1980).

[38] See 1 C. Koch. *Administrative Law and Practice* section 4.112 at 323 (1965).

XXI. Proliferation

As set forth in considerable detail, *supra*, the evidence taken during the rulemaking proceeding has convinced the Board, contrary to its earlier belief, that eight possible units (seven plus guards) should be found appropriate in acute care hospitals. In reaching this conclusion, the Board has carefully considered the Congressional admonition against proliferation set forth in the legislative history of the 1974 health care amendments as well as its own strongly-held view that the number of units found appropriate should not be so many as to lead to a splintering of the workforce into the myriad of occupations and professions found within the industry. The Board has examined the units found appropriate to ensure they are not so numerous as to create a never-ending round of bargaining sessions, and that each unit represents truly distinctive interests and concerns. A number of groups of employees found appropriate have separate labor markets. A thorough examination of the record in this rulemaking proceeding has satisfied us that the health care units established by the Board do not constitute proliferation either in terms of the legislative history of the amendments or in the context of the history or realities of the industry.

We believe that Congressional and industry concern with proliferation was directed towards the fifteen to twenty plus units that had arisen in the health care and other industries prior to the amendments and the possibility of scores of units if each hospital classification were permitted to organize separately. IUOE Br. 96-97: Legislative History of the Coverage of Non-Profit Hospitals

Under the National Labor Relations Act at 113-114 (Senator Taft); Hearings on S. 794 and S. 2292 Before the Subcommittee on Labor and Public Welfare, 93rd Cong., 1st Sess. 1973 at 175 (David Brekke, Colorado Hospital Association), 181 (O. Ray Hurst, Texas Hospital Association), 188 (William Whelan California Hospital Association), Sidney Lewine, 138-139 (American Hospital Association), 563-564 (exchange between Senator Taft and Andrew Biemiller of the AFL-CIO). See also testimony in 1971 and 1972 hearings, cited in IUOE Br. 96-97.

By 1974, a number of state and agency decisions with respect to non-profit hospitals, and Board decisions with respect to proprietary hospitals, had permitted each profession, and in some cases each craft, to form a separate bargaining unit (See discussion in AFL Br. 2-3, 28). As stated in Senator Taft's proposal, Congress feared that patterns such as developed in construction and newspaper industries –wherein units were permitted for each craft, resulting in 15-20 or more units – would result in separate units for the equally, if not more, numerous classifications in a hospital. We find no evidence that Congress opposed a smaller number of units. Thus, Senator Taft's proposal, containing special rules for the health care industry, would have established five units as presumptively appropriate: Technical, clerical, service and maintenance, all professional, and guards, two more than the statutorily mandated three units (professional, nonprofessional, and guards). The Board's addition of three units, RNs, physicians, and skilled maintenance, raising the total number of proposed possible units to eight, still constitutes half or fewer of the number of units that seem to us to have concerned Congress.

Furthermore, the record shows that the hospital industry understood proliferation to mean a much greater multiplicity of units than is proposed here. The League of Voluntary Hospitals of New York, an association of 54 nonprofit medical centers, hospitals, and nursing homes, and the largest organization of its kind in the country, supported the 1974 amendments because the League wished to remove itself from New York State health care coverage under which there were potentially 15-20 or more units in a health care facility (WS Abelow). Indeed, the American Hospital Association proposed a five-unit configuration: Professional, technical, clerical, service and maintenance, and guards. Hearings on S. 794 and S. 2292 Before the Subcommittee on Labor and Public Welfare, 93rd Cong., 1st Sess. 1973, Sidney Lewine, 140.

There is little evidence that the number of units proposed by the Board will result in proliferation or in the problems perceived to arise from proliferation. The units proposed by the Board are only potential units. Indeed, two of the units, physicians and guards, are rarely sought. A successful organizing effort in one unit in a hospital does not appear to have a ripple effect causing further organization. The record shows that from the 1974 health care amendments until the Board's 1984 decision in *St. Francis II*, most health care units fell into the categories now proposed by the Board. However, the majority of organized hospitals only had one unit, and about 80% had three or fewer units. (AFL Exh. 5 p. 1; SEIU, WS Shea, Table 2.) Nor, as detailed *supra*,was there a showing that the configuration of units proposed by the Board have resulted in an increased number of strikes,

jurisdictional disputes, or other disruptions in the delivery of health care services.

Finally, as shown above, the empirical evidence submitted in these proceedings strongly supports the appropriateness of each of the units proposed by the Board.

For all the above reasons, we conclude that our proposal for seven units plus guards is not only well within our discretion, but also consistent with both our own and Congress' concerns about proliferation.

XXII. Docket

The docket is an organized and complete file of all the information submitted to or otherwise considered by the NLRB in the development of this proposed rulemaking. The principal purposes of the docket are: (1) To allow interested parties to identify and locate documents so they can participate effectively in the rulemaking process; and (2) to serve as the record in case of judicial review. As provided in the first NPR (52 FR 25148), the docket, including a verbatim transcript of the hearings, the exhibits, the written statements, and all comments submitted to the Board, is available for public inspection during normal working hours at the Office of the Executive Secretary in Washington, D.C.

XXIII. Regulatory Flexibility Act

As required by the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, the Board certifies that the proposed rule will not have a significant economic impact on small entities. Prior to this rule, parties before the Board were

required to litigate the appropriateness of a unit for election purposes if they could not reach agreement on the issue. Upon enactment of this rule, parties will no longer be required to engage in litigation to determine the appropriateness of units, thereby saving all parties the expense of litigation before the Board and the courts. To the extent that organization of employees for the purpose of collective bargaining will be fostered by this rule, thereby requiring small entities to bargain with unions, and that employees may thereby exercise rights under the National Labor Relations Act, as amended (29 U.S.C. 151 *et seq.*), the Board notes that such was and is Congress' purpose in enacting the Act and the health care amendments thereto.

XXIV. Regulatory Text

List of Subjects in 29 CFR Part 103

Administrative practice and procedure, Labor management relations.

For the reasons set forth in the prior pages, it is proposed to amend 29 CFR Part 103 as follows:

Part 103 – OTHER RULES

1. The authority citation for 29 CFR Part 103 is revised to read as follows:

Authority: 29 U.S.C. 151, 156; 5 U.S.C. 500, 533.

2. Subpart C, consisting of § 103.30, is added to read as follows:

Subpart C – Appropriate Bargaining Units

Sec.

Subpart C – Appropriate Bargaining Units

§ 103.30 Appropriate bargaining units in the health care industry.

(a) This portion of the rule shall be applicable to acute care hospitals, as defined in paragraph (f) of this section: Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for petitions filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that various combinations of units may also be appropriate:

(1) All registered nurses.

(2) All physicians.

(3) All professionals except for registered nurses and physicians.

(4) All technical employees.

(5) All skilled maintenance employees.

(6) All business office clerical employees.

(7) All guards.

(8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards.

(b) Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B), the Board shall find appropriate only units which comport, insofar as practicable, with the appropriate units set forth in paragraphs (a) (1) through (8) of this rule.

(c) Nothing shall prevent the Board from holding additional hearings concerning the specific job classifications to be included in, or excluded from, each of the above units, and from establishing additional rules about such matters.

(d) The Board will approve consent agreements providing for elections in accordance with paragraph (a) of this section, but nothing shall preclude regional directors from approving stipulations not in accordance with paragraph (a), as long as the stipulations are otherwise acceptable.

(e) This rule will apply to all cases decided on or after the effective date of the final rule.

(f) For purposes of this rule, the term "acute care hospital" is defined as a short term care hospital in which the average length of patient stay is less than thirty days. The term "acute care hospital" shall include those hospitals primarily operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, or psychiatric care, but shall exclude facilities that are primarily nursing homes

or primarily psychiatric hospitals. The definition of "psychiatric hospital" shall be as set forth in 42 U.S.C. Sec. 1395 x (f), Social Security Act. A "non-conforming unit" shall be defined as a unit not in conformity with paragraphs (a) (1) through (8) of this rule.

(g) Appropriate units in all other health care facilities: The Board will establish appropriate units in other health care facilities, as defined in section 2(14) of the National Labor Relations Act, as amended, on a case-by-case basis.

XXV. Dissenting Opinion

Member Wilford W. Johansen, dissenting:

As amply documented in the Notice of Proposed Rulemaking in the Federal Register on July 2, 1987, there has been no universal acceptance in the circuit courts of a standard for formulating appropriate units in the healthcare industry. Some courts have simply substituted their own judgment for that of the Board on the question of what constitutes an appropriate unit. Frequently a court has apparently supported its conclusion by a selective reading of portions of the legislative history of the 1974 Amendments. The Board in turn has reacted first by trying to explicate that the differences might be "largely semantic" (*Newton-Wellesley Hospital*, 250 NLRB 409 (1980)), then by reversing field and adopting the test advocated by the Ninth Circuit (*St. Francis Hospital*, 271 NLRB 948 (1984) (*St. Francis II*)). That course in turn was roundly criticized by the D.C. Circuit. (*Electrical Workers IBEW Local 474 v. NLRB (St. Francis. Hospital)*, 814 F.2d 697

(1987)). The Board's reaction was to try yet a different approach – i.e., rulemaking.

With all due respect, I disagree. Rulemaking in regard to healthcare units is neither desirable nor appropriate.

First, it is my view that the appropriate method for resolution of questions surrounding the interpretation of Congress' intent, the proper scope of review, and the Board's duty and authority under the statute, is to submit these questions to the Supreme Court, which is the final arbiter on issues of this nature. Submission to the Court is especially appropriate in this area. Second, the Board has received criticism from the courts at both ends of the spectrum. Most of the criticism and disagreement has centered around application of the traditional community of interest standard, versus a separately derived "disparity of interest" test for evaluating units in the healthcare industry.

Thus, the Ninth Circuit, in an early *St. Francis* hospital case, faulted the Board for applying what the court deemed a too rigid presumption *in favor* of a registered nurses unit; and enunciated a "disparity of interest" standard, which it deemed necessary for assessing healthcare units. More recently, after the Board itself decided to adopt the disparity of interest standard, the District of Columbia Circuit in yet another *St. Francis* case, severely criticized the Board's action, and strongly "suggested", that some form of the historically accepted community of interest standard is required. Hence the Board is faced with some courts which have indicated a definite preference for the so-called "disparity of interest" analysis.

Other courts are equally adamant that nothing in the 1974 Amendments indicates that the Board was to abandon the community of interest standard which had served well for the previous forty years, and of which Congress was cognizant at the time of the Amendments.

It is apparent that the disagreements involve questions concerning the meaning of the statute, analysis of the legislative history, and the deference to be properly accorded to the Board's reading and interpretation of the Act, which is the Board's primary function and responsibility. These questions are all particularly appropriate for submission to, and final resolution by, the Supreme Court. This avenue is also the one which best serves the interests of the parties, the general public, and the Board itself.

Section 9(b) of the Act provides that

> The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof . . .

I do not read the above language as permissive. It is mandatory. The Board cannot satisfactorily fulfill its statutory obligation by relegating its specialized decisional function in this area to rulemaking procedures. That is not to suggest that I disapprove of rulemaking per se. On the contrary, I agree that rulemaking is desirable, and even a necessary part of the Board's function, in some areas. This is not one of those areas. I believe it is important to keep in mind that Congress did *not* amend Section

9 when it enacted the Healthcare amendments in 1974. Had Congress intended that the Board abandon the decisional approach and utilize a wholly new procedure for determining appropriate units in the healthcare industry, Congress would have told us so explicitly. It did not. Nor did it even implicitly suggest such action. The rule changes cited by the majority (e.g., contract bar, *Excelsior* list, etc.) in support of this radical departure from 50 years of Board precedent, (a) were arrived at decisionally, and; (b) did not involve unit determinations.

There are additional factors which make rulemaking on particular units, at best, inadvisable. Units established by rulemaking will continue to be criticized by courts that deem the Board's approach to healthcare unit determinations to be too rigid. Indeed, as unit specifications derived from a predetermined set of rules are inherently less flexible than those arrived at by decision in individual cases, criticism by some courts may even intensify on the ground that the Board has not arrived at a result through the application of its institutional expertise to a particular fact pattern.

Contrary to the stated expectations of my colleagues, setting unit configurations by rulemaking will not in fact substantially reduce the amount of litigation in this area. It may serve to change part of the focus of that litigation, while at the same time creating more. The amount of evidence produced in rulemaking is not the point. The difficulties encountered over the last several years have not been for lack of evidence. Rather, they have revolved around differing interpretations of the statute and, particularly, the legislative history and the deference to be accorded the Board and its expertise in its role as the

primary decision maker under the Act. I do not see that announcing rules by administrative fiat will resolve the divergent views on these fundamental questions. We still will not have obtained a definitive resolution of the basic issues which is so sorely needed.

I would, therefore, vacate the notices of proposed rulemaking and submit the extant issues to the Supreme Court for resolution.

Dated, Washington, DC, August 25, 1988.

By direction of the Board.

National Labor Relations Board.

John C. Truesdale,

Executive Secretary.

[FR Doc. 88-19688 Filed 8-31-88; 8:45 am]

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NATIONAL LABOR RELATIONS BOARD

29 CFR Part 103

Collective-Bargaining Units in the Health Care Industry

AGENCY: National Labor Relations Board

ACTION: Final rule.

SUMMARY: The Board issues a Final Rule providing for appropriate bargaining units in the health care industry. The Board has determined that establishing bargaining units by rulemaking will better effectuate the purposes and policies of the National Labor Relations Act than continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case.

EFFECTIVE DATE: May 22, 1989.

FOR FURTHER INFORMATION CONTACT: John C. Truesdale, Executive Secretary, 1717 Pennsylvania Avenue NW., Room 701, Washington, DC 20570, Telephone: (202) 254-9430.

SUPPLEMENTARY INFORMATION: The following is an outline of the contents of this Supplementary Information:

I. Background

On September 1, 1988, the Board issued its Second Notice of Proposed Rulemaking (NPR II) (53 FR 33900), modifying in some respects the rule tentatively proposed in its original Notice of Proposed Rulemaking (NPR) (52 FR 25142). Member Wilford W. Johansen dissented from the Board's decision to proceed with rulemaking. For reasons set forth in NPR II (53 FR 33901), the Board provided for another period of comment on all aspects of the proposed rule; that period ended October 17, 1988.

During this additional comment period, the Board received approximately 1500 timely comments. A number of comments received through Congressional offices were copies of letters also sent directly to the Board. On March 23, 1989, the Board met in open session to discuss further the issue of appropriate bargaining units in the health care industry, and this Final Rule is the product of that open meeting. The Board is appreciative of the extensive interest shown by all segments of the health care industry during this rulemaking proceeding, and has carefully considered the entire record during its deliberations. Though this Supplementary Information contains references to various comments submitted during this final phase, the Board wishes to emphasize now, as it did earlier (53 FR 33901), that these references are merely

illustrative. The Board's decision has been based on the complete rulemaking record, including the transcript, the witnesses' statements, all comments and briefs, and the exhibits, and not solely on the testimony and comments referred to in NPR, NPR II, and this Supplementary Information.

Approximately 30 of the comments submitted during this final comment period support the Board's proposal in whole or in part, and approximately 1465 comments oppose it. Of the 1465 comments in opposition, approximately one-half are form letters, for the most part containing brief arguments without supporting detail.

The most common form letter, submitted by over 600 correspondents, briefly exhorts the Board to return to the case-by-case approach and to find appropriate only two units, all professionals and all nonprofessionals, plus the statutorily-mandated separate unit of guards. Otherwise, say these commenters, their ability to provide comprehensive, coordinated care would be adversely affected. An example of this form letter is that submitted by St. Luke's Hospital in Bethlehem, Pennsylvania (Comment 434). The form letter contains blank spaces for such information as "(name of organization)"; "(number)" of health care facilities owned by the commenter; and "(number)" of employees; one submitted copy of the form letter did not have the blanks filled in.

A second form letter, such as that submitted by St. Mary's Health Center of St. Louis, Missouri (Comment 875), has been received from approximately 35 commenters, and contains only four sentences. This letter also asks the Board to abandon rulemaking and return to a

case-by-case analysis, arguing that, in ways not specified, the rule will increase the risk of life-threatening strikes and result in jurisdictional disputes, inefficient work rules, and higher consumer costs.

The other two most frequently submitted form letters are those received from the Humana chain and its affiliates; over 35 copies of these two form letters have been received. Illustrative of one type is that received from Humana Hospital-Winn Parish (Comment 1474). This letter argues that the proposed rule fails to consider the differences in hospitals and specific circumstances of employees at a time of dynamic change in the industry, could limit flexibility in dealing with personnel at a time this flexibility is needed, and will result in increased costs at a time of growing demand for cost containment. This letter urges the Board to continue a case-by-case analysis, arguing that the rule contravenes Congressional intent.

The other Humana form letter was that submitted by Steven L. Durbin, Vice President of Employee Relations/ Education, Humana Inc. (Comment 905), which makes similar arguments but also gives various examples of duties nurses now undertake (e.g., as in service education, utilization review and discharge planning, or admissions), to show changes in the industry. The letter adds that two proposed units, skilled maintenance and other professionals, would be very small units. The letter argues that the Board's rationale in its proposed rule has inconsistencies regarding salaries of nurses and uniformity in the industry. The letter further argues that the Board is abandoning *St. Francis II (St. Francis Hospital,* 271 NLRB 948 (1984)) to save time and resources for itself and

suggests other mechanisms for dealing with these problems.

Of the remaining one-half of the comments which oppose the proposed rule, the vast majority make general arguments with little, if any, supporting detail, and many contain portions of the form letters. The arguments in these comments, which for the most part mirror those made during the earlier portions of the rulemaking proceeding, generally fall within the following categories:

a. The health care industry is unfairly being singled out for rulemaking.

b. Rulemaking is contrary to the language of section 9(b), requiring a case-by-case approach.

c. The Board should follow the case-by-case approach of *St. Francis II.*

d. The number of proposed units conflicts with the Congressional admonition against proliferation.

e. If the Board establishes units, there should be only two units, professional and nonprofessional, plus guards.

f. The proposal will lead to increased organizing by unions.

g. Multiple units will result in strikes, repeated strike notices, jurisdictional disputes, and other disruptions of health care.

h. Health care costs will substantially increase as a result of strikes, whipsawing, work rules, bargaining, and contract administration.

i. Hospitals will lose needed flexibility.

j. The Board did not consider the changes in the industry such as teams, and the differences between institutions and between employees.

k. The particular units proposed, such as RN and skilled maintenance, are inappropriate.

l. The implementation of the proposed rule will lead to increased litigation.

m. At least 75 commenters argue that the Board should not treat small, rural hospitals as it does other acute care hospitals because they have less money and staff flexibility, and more overlapping employee duties. Moreover, disruptions at these facilities would have a severe impact on providing health care and employment for persons living in their areas since there are few or no other medical facilities nearby. Many of the 75 commenters provide no further detail on this point.

n. Several commenters embrace the arguments made by Member Johansen in his dissent from the Board's decision to continue with rulemaking.

o. Some commenters argue that the Board is inappropriately foreclosing discussion on bargaining unit issues by refusing to hear evidence on issues considered during rulemaking.

p. About 25 commenters argue that no rule should be made with less than a full five-member Board.

q. Some commenters suggest that the Board consider alternative to a rule, such as a Board panel deciding health care cases.

r. A few commenters argue that the implementation of the Board's proposed rule will expedite the Board's election process resulting in insufficient time for an employer to respond to a union's organizing campaign.

s. Some comments criticize the extraordinary circumstances provision as being too narrow.

The Board has carefully considered all the above arguments. Some (a, c, e, f, g, j, k, l, and n) were thoroughly dealt with in NPR and NPR II, and the Board believes that no further consideration or response is required. As to these arguments, the Board reaffirms the Supplementary Information and rationale contained in NPR II, as well as pertinent parts of the original NPR.

The point made by the 25 commenters referred to in "p" is moot, since all five Board Members have participated in the consideration and promulgation of this Final Rule.

With respect to the point made in "r," it is the Board's expectation that the rule will reduce what has hitherto been excessive delay and uncertainty in determining the appropriate bargaining unit, but otherwise all the Board's normal processes remain.

With respect to the remaining arguments: argument "b" is considered at II; "d" at XIII; "h" at III; "i" at IV; "m" at VII; "o" at II and XII; "q" at II; and "s" at XII.

The Board acknowledges and has taken into consideration the numerical superiority of the comments opposing the rule proposed in NPR II. From the beginning of this proceeding, employers have preferred continued use

of the adjudicatory approach,[1] and labor organizations have favored rulemaking. Since there are many more hospitals than unions in the health care industry, the disparity in the number of comments is not surprising. Although there are exceptions, the comments are for the most part divided pro and con along employer-union lines.

We do not view our task as similar to that of a scale-master, weighing the total body of comments for quantity without regard to substance. Insofar as we have found particular comments to be persuasive, we have reflected that in revisions to the rules previously proposed. To the extent we have found comments to be unpersuasive, we have so indicated in these and previous Supplementary

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[1] The Board in NPR II at 33229 stated, in the introduction to Section XIV on Specialized Hospitals, "Some employers suggested that the Board make a separate rule for specialty hospitals, arguing that they are neither acute care hospitals nor nursing homes * * * ." Attorney Roger King, among others, was cited, TR 4230-31. In Comment 1142, Bricker & Eckler correctly points out that King's argument at the cited pages was that today's hospitals are varied and complex, and that rulemaking is "not suited for those institutions." The commenter is correct: throughout these proceedings, King has opposed rulemaking in every form, for all institutions. However, the Board intended at the point in question merely to introduce the discussion as to whether specialty hospitals should be covered by the rule; reference to a separate rule for such hospitals was inadvertent, and that possibility was not considered by the Board in NPR II. In fact, the Board excluded psychiatric hospitals from the proposed rule, it did not make a separate rule for them. The misstatement about King's testimony as to this point was immaterial to the Board's deliberations but is hereby acknowledged and corrected.

Information sections. The Board "is not required to mold its decision to accord with the weight of the comments it receives." *M.C.I. Telecommunications Corp. v. FCC*, 675 F.2d 408, 415, n. 39 (D.C. Cir. 1982), cited with approval in *Telocator Network of America v. FCC*, 691 F.2d 525, at 538 (D.C. Cir. 1985). Cf. *Lloyd Noland Hospital & Clinic v. Heckler*, 762 F.2d 1561 (11th Cir. 1985).

II. Rulemaking

In both prior Notices, the Board set forth at considerable length the reasons prompting it to embark on rulemaking to establish appropriate bargaining units in the health care field. These reasons are set forth fully at 52 FR 25143 through 25145, and 53 FR 33901 through 33904, and are still valid.

Both the AFL-CIO (AFL) in its brief filed jointly with eleven other labor organizations (Comment 1713), and the American Hospital Association (AHA) in its brief (Comment 1711), deal at length with the Board's authority under section 9(b) to engage in rulemaking in the area of appropriate bargaining units. See also Comment 1055, Eastern Hospital; Comment 1330, Taft, Stettinius & Hollister; Comment 1663, Labor Policy Association; and Comment 379, James T. O'Reilly (supporting), among others.

Section 9(b) of the National Labor Relations Act requires the Board to decide "in each case" what the appropriate bargaining unit shall be. At the same time, section 6 gives the Board general authority to make rules, in the manner set forth in the Administrative Procedure

Act, "as may be necessary to carry out the provisions of this Act."

We have carefully examined the legislative history of these sections, particularly that surrounding section 9(b), and find nothing to impugn the legitimacy of this rulemaking proceeding. The words "in each case" were added to S. 1958 by Secretary of Labor Perkins, along with a number of other changes, as "small amendments" to be "made for the sake of clarity." I Legislative History (1935) at 1442 (Hearing 3/12/35.) A later House version of the bill, HR 7978 (5/9/35), contained the "in each case" language (II Legislative History at 2903), although earlier House bills had not. The House Committee Report, submitted by Representative Connery, stated:

> Section 9(b) provides that the Board shall determine whether, in order to effectuate the policy of the bill (as expressed in sec. 1), the unit appropriate for the purposes of collective bargaining shall be the craft unit, plant unit, employer unit, or other unit. This matter is obviously one for determination in each individual case, and the only possible workable arrangement is to authorize the impartial governmental agency, the Board, to make that determination. There is a similar provision in the Railway Labor Act of 1934 (sec. 2(9); 2(4)). (II Legislative History, supra, at 2976.)

The AFL suggests that the National Mediation Board (NMB), which administers section 2(9) of the Railway Labor Act, has defined units in the airline industry on an industry-wide basis as the result of industry-wide proceedings. If that were so, it would seem clear, consistent with Congressman Connery's analogy, that the Board could decide units for an entire industry also. However,

the cases cited by the AFL in its comment (p. 12, n. 18), are not fully supportive of its position. Though the NMB has used industry-wide proceedings for bargaining unit determinations in the airline industry, its pronouncements in each of the six proceedings that have been called to our attention have been limited to the particular airline involved.

For the reasons set forth in the NPR and NPR II, including the virtually unanimous views of courts, scholars such as Kenneth Culp Davis, and many other experts, we believe that our use of our rulemaking authority in this area is well within our discretion. In addition to the reasons previously given, we note that the Board has long made use of "rules" of general applicability to determine appropriate units, for example: (1) That single facility units are presumptively appropriate. *Haag Drug Company, Inc.*, 169 NLRB 877 (1968). See also *NLRB v. New Enterprise Stone & Lime Co.*, 413 F.2d 117 (3d Cir. 1969); (2) that residual units are not separately appropriate when sought by an incumbent. *The Budd Co.*, 154 NLRB 421 (1965); (3) that plant clericals and office clericals do not constitute an appropriate unit absent agreement of the parties. *The Kroger Co.*, 204 NLRB 1055 (1973); *Robbin & Myers, Inc.*, 144 NLRB 295 (1963); (4) that the appropriate unit in decertification elections is the certified or recognized unit. *Campbell Soup Co.*, 111 NLRB 234 (1955). See also the "rules" described in *Otis Hospital*, 219 NLRB 164, 166 (1975), pertaining to the appropriateness of residual units in the health care industry.

We are aware of no judicial criticism of the Board's longstanding use of "rules" in the appropriate bargaining unit area, and the Supreme Court in *NLRB v. Wyman-*

Gordon Co., 394 U.S. 759 (1969), strongly suggested that, when it promulgated "rules," the Board would be better advised to utilize its rulemaking powers under the Administrative Procedure Act (APA). The Supreme Court similarly endorsed the Board's use of its rulemaking powers in *NLRB v. Metropolitan Life Insurance Company*, 380 U.S. 438 (1965), at 444, n. 6, when, in remanding a bargaining unit case to the Board, the Court stated:

> Of course, the Board may articulate the basis of its order by reference to other decisions or its general policies laid down in its rules and its annual reports, reflecting its "cumulative experience," so long as the basis of the Board's action, in whatever manner the Board chooses to formulate it, meets the criteria for judicial review. (Citations omitted.)

There is nothing inconsistent between section 9(b) and the Board's use of its APA rulemaking power. Section 9(b) requires the Board to decide the appropriate unit in each case, and the Board will continue to do so under this rule. Should the parties not agree on the appropriate unit, a hearing in each case will still be directed, with the Board ultimately rendering a decision on the appropriate unit applicable to that particular petition and that particular employer's operation. The Board may rely on a rule properly promulgated under the APA just as it has, since 1935, relied on rules formulated under adjudication. The Supreme Court said as much in a recent case arising under the Social Security Act. That Act, like the NLRA, requires determinations (of disability) to be made on an individual basis, after hearings, if the issue is in dispute. Because of similarities between cases, the Secretary of Health and Human Services promulgated, through

rulemaking, a grid or matrix, through which it could be determined, with considerable predictability and uniformity, whether disability in a particular case existed. In *Heckler v. Campbell*, 461 U.S. 458, 467 (1983), the Court stated:

> We do not think that the Secretary's reliance on medical-vocational guideline is inconsistent with the Social Security Act. It is true that the statutory scheme contemplates that disability hearings will be individualized determinations based on evidence adduced at a hearing. See 42 U.S.C. sec. 423(d)(2)(A) (specifying consideration of each individual's condition); 42 U.S.C. sec. 405(b) (1976 ed., Supp. V) (disability determination to be based on evidence adduced at hearing). But this does not bar the Secretary from relying on rulemaking to resolve certain classes of issues. The court has recognized that even where an agency's enabling statute expressly requires it to hold a hearing, the agency may rely on its rulemaking authority to determine issues that do not require case-by-case consideration. See *FPC v. Texaco Inc.*, 377 U.S. 33, 41-44 (1964); *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956). A contrary holding would require the agency continually to relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding. See *FPC v. Texaco Inc., supra*, at 44.[2]

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[2] In *Heckler*, the Court noted that, at the statutorily-required "hearing," the claimants would be given "ample opportunity both to present evidence relating to their own abilities and to offer evidence that the guidelines do not apply to them (footnote omitted)." (Id. at 467.) Similarly, here, if the parties do not execute one of the Board's stipulated or consent

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As indicated, some of the form letters, as well as Comment 884a, submitted by Martha Jefferson Hospital, Comment 1049 submitted by Vanderbilt University School of Nursing, and Comment 905, by Humana Inc., suggest as an alternative that the Board establish special panels "in the Regions and Washington to hear, decide and resolve health care bargaining unit issues." This is

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agreement forms, and the petition is not dismissed for administrative reasons, there will be the hearing required by section 9(c) of the Act. At the hearing, the facility being organized, or the union, will be given ample opportunity to demonstrate that the unit guidelines are not applicable to it for such reasons as (a) the facility is not a hospital; (b) insufficient numbers of its patients receive acute care; (c) it is primarily a nursing home; (d) it is primarily a psychiatric hospital; (e) it is primarily a rehabilitation hospital; (f) its situation presents "extraordinary circumstances"; etc.

Moreover, we note that, under section 9(c) of the NLRA, the "hearing" requirement is not specifically related to the appropriate unit question, but rather, more generally, to whether a question concerning representation exists. Thus, although now the Board will in most cases render a decision on one subsidiary issue – the scope of the appropriate unit – on the basis of this rule, the Board will resolve other issues, such as whether a contract bar exists, whether certain employees are supervisory or managerial, whether the petitioner is a labor organization or has a conflict of interest, whether a single facility unit is appropriate, the composition of the appropriate unit, etc. on the basis of testimony taken at the hearing. The Board has merely determined that the issue of the scope of the appropriate unit within an acute care hospital does not generally require adjudicatory consideration, and that otherwise it would have "continually to relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding." *Heckler v. Campbell*, supra at 467.

neither feasible nor helpful. Only the Board members themselves can resolve contested cases, including unit issues. *KFC National Mgmt. Corp v. NLRB*, 497 F.2d 298 (2d Cir. 1974). The Board normally decides representation cases (as well as other cases) by panels of three members, and to create a permanent panel of three would not be likely to improve efficiency, and instead might result in delay. Moreover, it would unjustifiably exclude the other two members. Because of the volume of cases before it, the Board simply cannot hear oral arguments except in very unusual cases, and we are aware of no useful purpose that would be served by sending Board members to regional offices to decide health care cases. Sitting in the locale of the contested case would not add to the members' understanding of the case.

Some commenters suggest the use of rebuttable presumptions. The Board has previously rejected that suggestion, for the reasons set forth in NPR at 52 FR 25145. The Board's experience since 1974 is that painstaking elicitation and examination of the facts of each individual case is, absent extraordinary circumstances, neither helpful nor outcome determinative as to the scope of the appropriate unit. See NLRB Exhibit 5, revised, referred to in NPR II at 53 FR 33903. The use of mere presumptions would not eliminate the duplicative litigation referred to by the Supreme Court in *Heckler v. Campbell*, but establishing units by rulemaking will go a long way towards accomplishing that objective.

Finally, although we are highly satisfied with this rulemaking proceeding both because of the large amount of valuable information it has given us and because, based on that information, we are confident we have

moved towards eliminating much of the unnecessary uncertainty existing in this area, we are under no illusions that the answers we now provide will necessarily solve all health care unit problems, for all time. This is our first venture in major, substantive rulemaking. At some future date, after the rule has had a fair trial, it may be appropriate to reexamine the rule to determine how well it has worked, whether new developments have changed our underlying assumptions and require different conclusions, and whether some other provisions might improve those now promulgated.

III. Cost Considerations

Strikes and strike costs were dealt with at some length in NPR II. (53 FR 33908-33910.) Though the comments following NPR II did not challenge the Board's finding there that the incidence of strike activity in the health care industry has been lower than in all other industries (53 FR 33908), industry commenters identify approximately 20 strikes that have taken place. A number of employers report that they have experienced one strike (e.g., Comment 1706, Ellis Hospital; Comment 1718b, Waterbury Hospital Health Center; Comment 1654, Pottsville Hospital and Warne Clinic; etc.). Two commenters report multiple strikes (Comment 1145, East Liverpool City Hospital, four in 20 years; Comment 1249, Santa Rosa Memorial Hospital, two strikes in last 8 years totalling 70 days plus four 10-day strike notices).

The evidence in NPR II showed that sympathy strikes in hospitals have been virtually nonexistent. (53 FR 33909.) Nonetheless, two hospitals now report sympathy

strikes. (Comments 1259 and 1729b, Bridgeport Hospital, regarding Waterbury Hospital; Comment 516, Saint Elizabeth Medical Center (sympathy strike by delivery drivers at unnamed hospital).)

The strikes reported in the aforementioned comments are insufficient in number or character to conflict with the Board's prior conclusions in NPR and NPR II.

A few hospitals discuss costs relating to their strikes. For example, in Comment 981, O'Bleness Memorial Hospital reports spending $20,000 for security forces and over $20,000 for legal and negotiating fees; two of the three times the hospital renegotiated its contract, the union issued a strike notice and the hospital incurred costs in strike preparation. Pottsville Hospital and Warne Clinic reports $20,000 in legal fees and staff time (Comment 1654). The only cost amounts we regard as possibly noteworthy involve Wadley Regional Medical Center and Santa Rosa Memorial Hospital. In Comment 937, Wadley states that, in 1978, its costs for a strike were "up to $1,000,000." Santa Rosa, in Comment 1249, reports its labor relations costs relating to two strikes, four strike notices, and three organizing campaigns, were "up to 5 million." In both instances, and in the absence of elaboration, the hospitals' use of the phrase "up to" leads us to believe that the amounts given are only upper-limit estimates and not careful calculations. Nor is there any indication whether these costs were largely wage increases, legal fees, lost revenues, overtime, remuneration of striker replacements, or even lost profits. Legal fees are, of course, highly individual. Where cost estimates include staff time, it is not clear how much of the staff's time was ordinary expense precommitted to be paid

regardless of whether there was a strike. See, e.g., Comment 1654, Pottsville. In any event, the costs of the small number of strikes mentioned do not seem disproportionate to what we believe Congress must have anticipated when it authorized collective bargaining in the health care industry by placing it under the Board's jurisdiction in 1974.

Approximately twelve commenters provided information regarding costs of bargaining. For example, in Comment 1684, Mon Vale Health Resources, Inc. reports it spent $40,000 in the last negotiations with its nonprofessional unit and $8,000 for arbitration. In Comment 1714, Gerald Champion Memorial Hospital reports $16,000 for each of its negotiations. In Comment 1143, Lakeland Hospital estimates the cost from its one nonprofessional unit as $15,000 to $25,000. In Comment 1476, Brookhaven Memorial Hospital reports the cost of one unit's organizing campaign as 24 days of hearings and lost productivity, and $80,000 in legal fees. It is the Board's expectation that its promulgation of this rule establishing appropriate bargaining units will render lengthy scope-of-unit hearings unnecessary and to that extent some costs, such as legal fees, will therefore diminish. In any event, it would not be suitable for the Board to reject appropriate bargaining units on the basis that the very things sought by collective bargaining – negotiating and grievance processing – can be obtained only at some financial cost. The statutory amendments enacted by Congress in 1974 represented an implicit policy decision that collective bargaining in the health care industry will produce countervailing benefits justifying the cost.

IV. Employer Flexibility

Four commenters take particular issue with the Board's reasoning that rulemaking has no logical connection with an employer's continuing ability to respond flexibly to changing needs of the times. (53 FR 33904; see also 53 FR 33910).

Martha Jefferson Hospital (Comment 884A) argues that employees will resist change by seeking to join one of the units deemed appropriate. That argument has no support in the facts adduced during this proceeding; there has been no showing that unions have resisted changed job duties. Moreover, logically, the argument, if valid, would apply to some extent regardless of what units the Board finds appropriate, and regardless of the method the Board utilizes to determine the scope of appropriate units. It is true that union organization does lead to the requirement that employers bargain before making changes in wages, hours, and working conditions, but that is an obligation imposed upon all employers by the NLRA, and we have no basis upon which to exempt health care employers from these requirements. There has been no demonstration of undue resistance to change by health care unions.

The University of New Mexico Hospital (Comment 1022) suggests that jurisdictional disputes may arise but offers no examples to support its speculation; few if any were offered in the earlier stages of this proceeding either. (53 FR 33909). Based on the evidence presented to us, we conclude that jurisdictional disputes are infrequent in the health care industry generally. If such disputes were to arise, section 10(k) of the Act would be

available to assist in resolving them. Moreover, if there were several units in a facility, it is possible they would be represented by the same labor organization, which might work things out by itself.

Allegheny Health Services (Comment 1094) reasons that implementing a hospital-wide fitness policy, for example, including drug testing, would be more difficult or even impossible if bargaining had to be held with eight separate units. Even if that is true, the evidence shows that, at least in the past, very seldom have hospitals had more than two or three units. (52 FR 33933). Moreover, though no specific evidence was offered on this point, we suspect that other hospital-wide policies, such as holiday and vacation schedules, cafeteria benefits, parking privileges, etc., are uniform at many hospitals despite the presence of several units. Lastly, if one is to speculate, it could be argued with equal logic that an employer might have better success in negotiating a new plan with one small unit's representative, implementing that, and later using it as precedent for changes elsewhere, than it would in negotiating a new plan with a single labor organization representing many types of employees with diverse interests.

Taft, Stettinius & Hollister (Comment 1330) refers to a proposal by the American Medical Association for a new classification, RCT (registered care technician), in which employees could move up from aide to LPN to RN as they received additional training. Taft, Stettinius argues that, under the Board's proposed rule, employees within the RCT classification would be in three different units and therefore hospitals will lose flexibility in using RCTs. However, insofar as employees are in fact aides,

LPNs and RNs, they are, for reasons set forth in NPR and NPR II, entitled to be in separate units, and creating a new generic classification of RCT does not change that fact. Nor would any RCT be in more than one unit at a time, even though he or she might, over time, progress from one unit to another. In any event, at this time the development and implementation of the RCT classification is speculative. Taft, Stettinius' additional comment that hospitals would have to structure their staffs to conform to the proposed rule is supported neither by evidence nor reason. Physicians will still practice their specialty, as will RNs, technicals, etc. Nothing in the rule precludes hospitals from structuring their operations as they see fit.

V. Common Expiration Dates

In NPR II, the Board noted that "hospitals have not generally sought common expiration dates, which would be a possible solution to recurring near strikes." (53 FR 33909). The AHA argues (Comment 1711) that "common expiration of multiple contracts virtually would insure a complete cessation of operations, and thus, is an illogical, unworkable goal for hospitals to pursue or for the Board to use as support for its conclusions here." See also Comment 987, Dana-Farber Cancer Institute, which suggests that the Board should not criticize the health care industry for not availing itself of common expiration dates because there have been crippling strikes in New York, Minneapolis, and San Francisco as a result of the stategy of common expiration dates.

We accept the criticism of these commenters, but their argument proves too much. Simultaneous strikes that may occur on the occasion of common expiration dates would seem to support more rather than fewer units. An obvious charcteristic of a large bargaining unit would be that all employees' no-strike obligations would expire at the same time, and bargaining for the entire unit would take place at the same time. Although a small unit's work stoppage may not shut down the entire facility, a large unit's stoppage surely will. This point was made in NPR II, at 33909; see also *Manor Healthcare Corp.*, 285 NLRB No. 31 (1987), slip op. at 13, where the Board pointed out that "an employerwide unit in this situation would tend to broaden a given dispute and increase the potential for disruption of patient care."

VI. The Units

Surprisingly few comments offered additional facts which would be helpful to the Board in making a final decision with regard to the appropriateness of particular bargaining units.

Some additional information on teams was proffered, but the Board reaffirms its earlier conclusion as to the limited relevance of the so-called "team approach." See NPR II 33907; 33913. A few commenters state they have teams, like discharge planning, but do not detail interaction or demonstrate why separate units would prevent use of teams. One commenter, Bethesda North Hospital (Comment 1303), acknowledges that each discipline retains its particular area of accountability, but argues that "it is vital to the progress of the patient that they

each understand and can cross over into each other's area . . . ." See also Comment 1044, Missouri Hospital Association, which emphasizes that the Board has conceded the existence of teams, however widespread they may be.

On a related point, several commenters give examples of cross training. Comment 586, Marshalltown Medical and Surgical Center, describes its practice of having security guards work the switchboard and do maintenance work. However, such employees would necessarily be placed into the statutorily-mandated separate guard unit. Attached to Comment 586 is a newsletter from George E. Speese, a Human Resource Development consultant, who describes how an East Oregon hospital assigned switchboard duties to a "radiology tech," and how a Philadelphia hospital assigned nursing unit clerical duties to a phlebotomist. Similarly, Comment 1053, La Grange, states that certain non-unit jobs were performed by unit employees (dietary employees performed some outside maintenance duties, certified nurses' assistants performed some clerical duties, etc.). In such situations, La Grange argues, the Board's proposed rule would require it to carve out skilled maintenance and clerical functions into separate units. However, this argument is based on a misunderstanding of Board unit determinations as well as of the provisions and purposes of the rule. Board unit determinations do not require that certain types of work be assigned to any particular unit. To the contrary, employers are free to make whatever work assignments they wish, subject of course to their obligation to bargain before making any changes in working conditions. Where one employee is assigned functions relating to more that one unit, he or she is a "dual

function" employee, and, upon request, the Board will determine the unit placement of such employee. See, e.g., *Otasco, Inc.*, 278 NLRB 376 (1986); *Oxford Chemicals, Inc.*, 286 NLRB No. 13 (1987). In neither of the cited cases did the Board impose any restrictions on the employer's making cross-unit assignments; neither has the Board imposed such restrictions in any other case of which we are aware.

La Grange's comment also refers to medical technicians' being trained in at least 3 areas, including hematology, bacteriology, and histology. This comment is consistent with the observation of NPR II that "the majority of cross-training that occurs is among the technical categories themselves." NPR II at 33919.

Comment 1081, Wausau Hospital Center, discusses product line management. Employees have to work together, and sometimes are even supervised by an individual who may not be their direct line supervisor. The comment states that the Board misunderstands this concept and that multiple bargaining units jeopardize this program. As with cross-training, discussed above, this commenter does not explain how the Board's unit determinations would in any manner inhibit product-line management.

A small amount of additional information was offered as to the proposed separate RN unit. See Comment 1026, by Spelman Memorial Hospital, that, with 128 beds, RNs report to the same administrator as lab technologists and physical therapists. Moreover, RNs work in medical records along with other professionals. Comment 1330, Taft, Stettinius & Hollister, asserts that RNs are not

unique, since other professionals also have direct and continuous patient interaction, etc. This comment concedes that RNs are the "hub" of the professional administration of health care, but argues that to remove the hub and separate it from the spokes will cause the wagon to break down. Comment 1675, Middletown Regional Hospital, states that some of its nurses' former work is now done by social workers, and that nurses at this hospital share the same pay system and pay, as well as some common first line supervision, with other professionals.

The comment of Taft, Stettinius that all professionals interact with patients, fails to give sufficient weight to the adjective "continuous." The uniqueness of the RNs' function in this regard was thoroughly dealt with in NPR II at 33911, V, B, 2. The fact that in smaller hospitals there may be some common supervision does not cause us to reach a different result, particularly in view of the very few examples presented.

In Comment 1044, Missouri Hospital Association, through its attorneys, Spencer Fane Britt & Browne, takes issue with the Board's observation in NPR II that nurse licensing exams are uniform throughout the country. However, at TR 3595-98, witness Faith Reierson described national licensing exams in considerable detail. The National Council of State Boards of Nursing consists of the executive secretary and the members of the various nursing boards in the 50 states and 3 territories. Each of the states and territories has contracted with the National Council to provide that state or territory's licensing examination for RNs and LPNs. The same test is administered twice a year on the same day at the same time

(except for time zone variations) in each of the states and territories. No contrary testimony was introduced.

On January 19, 1989, the Secretary of Health and Human Services made public the report of his Commission on Nursing. This Commission was an advisory panel appointed to examine reports of a widespread shortage of registered nurses, and to make recommendations for resolving the shortage. We have examined the Commission's Report and find that it supports our observations in NPR II concerning the nursing shortage, unique problems confronting nurses, and the special need of nurses for their wage compression to be alleviated.

In Comment 975, American Physical Therapy Association urges the Board to create a separate unit for physical therapists, in part because of their separate licensure. The practice of physical therapy is administered in almost all jurisdictions by a separate board. The commenter represents, and it is undoubtedly true, that physical therapists have concerns peculiar to their speciality, such as interpretation of their practice act, private patient referral and access, home care extension services, and experimental structures for student clinical supervision. However, especially in view of their relatively small numbers and their limited history of separate bargaining (in New York, largely), as well as the Board's desire to limit the number of units unless there is strong justification presented in the rulemaking record, the Board declines to establish a separate unit for physical therapists. If found to be professionals, they are to be included with other non-RN and non-physician professionals. See NPR II at 33917-33918.

The Board affirms the appropriate unit findings made in NPR II, for the reasons set forth therein, and except to the extent modified in this Final Rule and accompanying Supplementary Information.

VII. Small Units

A number of commenters argue that the proposed "skilled maintenance" and "other professional" units, in particular, may be too small for collective bargaining purposes. See, e.g., Comment 1686, American Society for Personnel Administration, which represents that skilled maintenance frequently constitutes less than 2% of the workforce. See also, generally, Comment 905, Humana; Comment 562, The Methodist Hospitals (Indiana); Comment 1021, St. Elizabeth's Hospital; Comment 1044, Missouri Hospital Association; and Comment 1330, Taft, Stettinius & Hollister, Blanchard Valley Hospital (Comment 369), referred specifically to excessive administrative costs that may be associated with negotiations for very small units.

We recognize the possibility that some skilled maintenance units will be relatively small, as will some "other professional" units and some physicians' units. The same point has been made with respect to rural hospitals, whose small employee complements may also lead to very small units.[3] St. Vincent Hospital (Comment 1691)

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[3] Parenthetically, we noted that a large number of small rural hospitals call attention to their precarious financial condition. Comment 333, Holy Rosary Medical Center; Comment

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argues that in a Coronado Hospital with 105 beds, there would be bargaining units of 1-2 persons. In Comment 1044, Missouri Hospital Association hypothesizes that in a hospital of 20 beds, there might be more units than patients.

We doubt this situation will frequently arise. For one thing, it is likely this "problem" will be self-policing. Where the entire workforce is very small, we believe that even smaller sub-groups will seldom want separate units; nor will unions be likely to organize such small units. Moreover, we note that under adjudication, the Board rarely if ever reached different results because of the size of facility. In only one case, to our knowledge[4], did the Board arguably reach a different result because of the number of employees involved. In *Mt. Airy Psychiatric Center*, 217 NLRB 802, 803 (1975), one of the earliest cases decided after the 1974 amendments, the Board included two employees who *arguably* were technicals in the service and maintenance unit, since they were the only employees performing a "technical" function. Lastly, the Board did propose a 100-bed dividing line with fewer units for smaller hospitals in the first NPR, but industry

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1300, Bowie Memorial Hospital; Comment 1307, United Hospital Center; Comment 1673, Grayson County Hospital; Comment 967, Northern Maine Medical Center; Comment 1700, Weston County Memorial Hospital and Manor; etc. We do not consider the financial condition of rural or small hospitals relevant to a determination of appropriate bargaining units.

[4] But see also *Extendicare of West Virginia, d/b/a St. Luke's Hospital*, 203 NLRB 1232 (1973), which arose prior to the 1974 amendments.

and labor organizations were virtually unanimous in their opposition to it (53 FR 33927).

Despite the foregoing, and despite the improbability that the problem will frequently arise, we agree that units of two or three employees, or of similarly small numbers of employees, would in many cases be impractically small, especially in the health care industry. Where so few employees are involved, it can be argued with some degree or persuasiveness that despite the shared, unique concerns and backgrounds that would otherwise make the separate units appropriate, these concerns are outweighed by concerns over disproportionate, unjustified costs and undue proliferation of units. We therefore shall revise the rule to provide that a petitioned-for unit of five employees or fewer shall constitute an "extraordinary circumstance" removing the case from strict application of the rule, and the Board will consider by adjudication what the appropriate scope of the unit should be.[5]

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[5] Though, based generally on our prior experience as well as the evidence accumulated during this rulemaking proceeding, we have decided that a unit of five or fewer employees automatically triggers the "extraordinary circumstances" exception, we recognize that there is no ineluctable logic in the number five, and that other situations may occur in which a party may contend that the number of employees in the petitioned-for unit, or other circumstances, may require deviation from strict application of the rule. Thus, the "extraordinary circumstances" exception remains available (most commonly through an offer of proof – NPR II at 33933) for any party who wishes to argue for any reason that the rule should not be applicable to its facility. At the same time, we reemphasize that we do not intend for the "extraordinary circumstances" exception to "provide an excuse, opportunity, or 'loophole' for

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We recognize that situations involving small units may vary. Thus, in some situations, if the requested units were not deemed appropriate, the small, requested unit might have to be added to a vastly larger unit. On the other hand, a requested unit falling within this extraordinary circumstances exception might be considered in conjunction with one or more otherwise appropriate units of approximately the same size. Requiring a combination of these otherwise separately appropriate groupings may give rise to considerations different from those in the previous example. The Board will render appropriate decisions through its adjudicatory processes when the extraordinary circumstance provision is invoked in this situation. This approach will allow us to examine individual circumstances where justified, while eliminating unnecessarily repetitive litigation.

VIII. Equal Employment Considerations

Comment 1098, Myerson & Kuhn (position paper by Susan Warner), represents that RN units are dominated by females, 95-98%; physicians are dominated by males (primarily white), in one large medical center, 83%; technicals are dominated by females, 72-78%, with less than 50% minorities; other nonprofessionals are dominated

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redundant or unnecessary litigation." NPR II at 33932. The Board will not reconsider, under the "extraordinary circumstances" exception, the arguments it has already rejected in this exhaustive proceeding.

90% by minorities; business office clericals are predominantly female, and almost 50% white; and skilled maintenance is 85% male, 75% white. This commenter observes that hospitals are subject to Title VII of the Civil Rights Act of 1964, and argues that the proposed rule will defeat hospitals' efforts to integrate their workforces and provide opportunities for minorities and women. Hospitals will be hampered by negotiations with unions representing what are in effect segregated units, insuring that these units remain segregated. She points particularly to seniority and says most collective-bargaining agreements do not recognize seniority from other units, thus impeding upward mobility. Warner's cover letter expresses the opinion that this aspect has not been adequately explored and requests that the Board extend the comment deadline for this purpose. Her remarks are echoed by Comment 1508, Thomas Jefferson University Hospital.

This is a question that has previously concerned us also, and during the first round of hearings the Board's representative specifically asked, twice, for comments on this subject (see TR 5225, 5243), noting that former-Member Jenkins had raised the same question during the 1975 oral arguments held shortly after passage of the amendments.

Only two witnesses addressed the subject: Jerry Shea, SEIU's Director of the Health Care Division; and Cathy Schoen, consultant to SEIU and its former Research Director. Both testified at some length, answering questions raised by management attorney Roger King. Schoen submitted a supplemental statement addressing it further. SEIU has represented over a quarter million workers in the health care industry, through 80 separate locals.

The testimony of Shea and Schoen was that "balkanization," or rigid stratification within classifications, with little upward mobility, has been characteristic of the entire health care industry, representing the attitude of most employers that they would rather not lose a good worker and have not deemed it in their interest to provide training for promotions to other classifications; this has been done for bureaucratic and not for nefarious or uncaring reasons. They testified that the medical "model" characteristically organizes access to positions through outside education and licensure certification as opposed to, for instance, the apprenticeship model that operates in the skilled trades.

Schoen testified there is in effect a caste system, with employers preferring departmental seniority regardless of whether or not there is unionization, and that it has been unions that have attempted to break out of this system. (TR 5221 ff.) Frequently even with broad units there is departmental seniority. (TR 5242.) Some subgroups have successfully bargained for seniority across unit lines. (TR 5244-45.) In her Supplemental Comments, Schoen gives as examples of these exceptional cases Mt. Sinai in Chicago, where SEIU secured hospital-wide seniority for business office clericals, as well as bumping rights in the event of layoffs and Cape Code Hospital, where SEIU successfully negotiated hospital-wide mapping of jobs according to skills and entry level requirements, so employees could better see mobility paths. Schoen also notes the SEIU Local 250 contract for Kaiser in Northern California, covering 9,000 workers from service staff to pharmacists; there, seniority and promotion

accrue first by department, then by facility. Schoen concludes that there "is a narrow administrative orientation towards human potential that limits mobility – not the units in which workers choose to organize." A footnote to Schoen's Supplemental Comment lists three studies on this subject. Brief reference was made to this evidence in NPR II at 33910.

In view of the Board's express invitation on the record for further evidence on this subject, and the limited substantive response, the Board does not see a need for additional discussion. Having considered the comments and the record evidence on this issue, the Board affirms its prior conclusion that the evidence fails to show that the units found appropriate will limit minorities' or women's opportunities for job advancement and security, and may possibly have the opposite effect. (53 FR 33910.)[6]

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[6] In one adjudicated case, the Board adopted the conclusion of an administrative law judge that a bargaining unit limited to a coke department continued to be separately appropriate even through one of the parties alluded to a formal consent decree (*U.S. v. Allegheny-Ludlum Industries*, 63 F.R.D. 1 (N.D. Ala. 1974), affd. 517 F.2d 826 (5th Cir. 1975), cert. den. 425 U.S. 944 (1976)), the primary objective of which was to create transfer opportunities so that employees in departments like the coke department could move into other departments with higher skills. The purpose of the consent decree was to alleviate past alleged discrimination on the basis of race, sex, color, and national origin. As indicated, the Board found accretion was not appropriate, despite the existence of the consent decree. *Armco, Inc.*, 279 NLRB 1184 at 1184, 1214-15, 1218-19 (1986).

IX. Coverage of the Rule

Though not objecting to the Board's exclusion of nursing homes from the proposed rule, the AFL objects to the Board's summation of the evidence (NPR II, Section XII, at 33927-29), suggesting that the Board's conclusions might not be accurate and might prejudice future rulemaking by referring to lack of uniformity among nursing homes. Though we agree that our information as to nursing homes has been limited, we do not agree that this part of the prior Supplementary Information will in any way prejudice future proceedings that might involve nursing homes. Such proceedings would be based on evidence presented herein.

Only one commenter would include psychiatric hospitals, Comment 322, Union of American Physicians & Dentists. That suggestion was made not on the basis of specific facts or arguments on the merits, but rather because, in view of the many instances of common ownership and interlocking directorates, it would allegedly be relatively simple for "devious" attorneys to make a given facility fit within an exclusion. We have no good reason to believe that parties will attempt to dupe the Board into thinking that an institution is not what the facts make it out to be. In any event, such a remote possibility is an insufficient reason for including a type of facility which the Board finds, for reasons explained in NPR II at 33929-30, should not be covered by the proposed rule. We shall continue to exclude psychiatric hospitals from coverage of the rule.[7]

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[7] The same commenter requests the inclusion of non-acute care facilities such as HMO's for the same reason. We similarly reject this request.

In NPR II, the Board noted that it did not have much evidence on rehabilitation hospitals and various other specialty facilities, and so these facilities were "tentatively" included. See NPR II at 33931. Those who had commented had argued that care was integrated, but did not urge special treatment. NPR II, Section XIV.

New England Rehabilitation Hospital, Comment 952, represents that it is solely a rehabilitation facility, but that average patient stay has been decreasing and last year was just under 30 days. It documents more completely the integrated care required for comprehensive rehabilitation. For one thing, as with psychiatric hospitals, RNs are not the primary facilitators of patient care, and are significantly outnumbered by other professionals. Teams are used not only for special situations, but carry out day-to-day treatment for each and every patient. In all cases there is close integration between the work of RNs and that of physicians, therapists, social workers, psychologists and dieticians. RNs are not left to themselves on off-shifts; therapies are conducted on weekends, and social workers meet with patients and families evenings and weekends. Similar information is offered by Comment 1273. The Rehab Hospital of York, which states that its occupational therapists, physical therapists, and speech therapists continuously collaborate with physicians and RNs to develop and provide treatment for all patients. New England Rehabilitation Hospital has 198 beds; The Rehab Hospital of York, 250 employees.

The most extensive comment addressing this issue was that submitted by Specialty Hospital Group, part of National Medical Enterprises, Inc., Comment 970. That group includes 53 freestanding psychiatric hospitals, 23

freestanding rehabilitation hospitals, 18 freestanding substance abuse treatment facilities, and 100 managed facilities of the three varieties. First, it describes how AHA registers some hospitals as "rehabilitation" hospitals; average length of stay is not involved. Second, Congress exempts rehabilitation hospitals from Medicare's prospective payment system, and implementing regulations (42 CFR 4052) contain a specific, 7-part definition of a rehabilitation hospital. Rehabilitation hospitals may also be accredited by one of two bodies: Joint Commission on Accreditation of Healthcare Organizations (JCAHO), under different standards from those applied to regular hospitals, or by Commission for Accreditation of Rehabilitation Facilities (CARF). Accreditation by JCAHO or CARF automatically satisfies six of the seven criteria constituting the definition for Medicare prospective payment exclusion purposes: All except the requirement that, during the most recent 12-month reporting period, 75% of the inpatient population required intensive rehabilitative services for the treatment of one or more of certain specified conditions. Thus, exclusion of rehabilitation hospitals would be administratively feasible, claims this commenter.

Specialty Hospital Group further points out that one of the accreditation standards under the Medicare definition requires multidisciplinary care. Each patient must have at least three hours of physical or occupational therapy per day for Medicare to pay for the care as "medically necessary"; therefore, it is argued, nurses are not the primary facilitators of care in rehabilitation hospitals. Moreover, for Medicare coverage to apply, rehabilitation hospitals' patients must be medically stable before

they are admitted. Thus, it appears that the level of acuity at rehabilitation hospitals is considerably lower, and generalizations about job classifications and appropriate units at other types of hospitals may not apply.

Specialty Hospital Group does not ask for exclusion of alcohol and drug abuse hospitals (if there are any), but for clarification of the rule to make it clear that alcohol and drug abuse residential treatment facilities that are not hospitals are not covered.

The rule previously proposed covers only "acute care hospitals." An acute care hospital is defined as a "short term care hospital in which the average length of patient stay is less than thirty days." It seems likely that the acute care definition would exclude many rehabilitation, as well as drug and alcohol, facilities. Yet, if it is true, as New England Rehabilitation Hospital represents, that its average length of stay is now slightly below 30 days, such a hospital would be covered by the rule previously proposed, as an acute care hospital.

The Board has considered the comments submitted at this stage of the proceeding, pertaining to rehabilitation hospitals, and has decided that sufficient questions have been raised about appropriate units at such facilities that the rule should not be applied to rehabilitation hospitals. Many of the reasons given by the Board in NPR II for the exclusion of psychiatric hospitals (NPR II at 33929-30) now appear applicable to rehabilitation hospitals as well. Thus, for example, it appears that RNs may not be identifiable as the primary professional providers of patient care; RNs and other employee classifications function somewhat differently because patients are not as acutely

sick as in other types of hospitals, and because different methods of treatment appear required for rehabilitative care; and around-the-clock efforts may be more extensively required of all professional groups, and perhaps other employees as well. The Final Rule will not, therefore, cover rehabilitation facilities that have been accredited as such by either JCAHO or CARF, regardless of the average length of patient stay.

With respect to inpatient drug and alcohol treatment centers, it is possible they would be excluded either by (a) the definition of "acute care," relating to length of patient stay; or (b) the new exclusion for rehabilitation hospitals generally. No case has been made for exclusion of all drug and alcohol treatment facilities as a class, and regardless of whether they are hospitals. However, if particular drug and alcohol facilities are not hospitals, the rule is not intended to cover them. For purposes of clarification we have decided to include in the rule a definition of "hospital," apart from the definition of "acute care." The definition shall be that contained in the Medicare Act, currently to be found at 42 U.S.C. 1395x(e), as revised in 1988, and incorporated by reference in the Final Rule's definitions.

X. Miscellaneous Problems

(a) *Definition of "acute care."* AFL contends that use of the "acute care" definition in NPR II might "skew" the average length of stay if a hospital has a large number of long term beds or swing beds. AFL points out that AHA alternatively defines a "short term" hospital as one in which over 50 percent of all patients are admitted to units

where the average length of stay is less than 30 days." In view of the very high patient acuity level in hospitals today, we doubt that there would be many situations in which a sufficient number of long-term days by a few patients would skew the average. However, we agree with AFL that the Board's intention may be better realized by addition of the alternative definition. One long-term patient in a small, otherwise acute care hospital should not serve to define the character of the hospital. Accordingly, we shall revise the Final Rule to encompass the alternative definition as well.

(b) AFL suggests that parties may try to persuade the Board that, even though a facility is not "primarily" any one of the excluded types of institutions, it still is not "primarily" an acute care hospital, perhaps because it has such a variety and/or multiplicity of other types of units it is not "primarily acute care," but rather some other amalgam type of institution. The concern of this commenter may be well placed. Many of today's hospitals have a number of other types of units, such as outpatient clinics, nursing care units, etc., and the Board did not intend to exclude such hospitals from coverage of the rule unless any one of the excluded ancillary services predominated. Nor did the Board intend to permit a hospital to argue successfully that since the number of its outpatient visitors exceeded the number of its over-night (acute care) patients, it was not an acute care hospital, and therefore not subject to the rules. In order that there not be unintended litigation, we shall, in the Final Rule, delete the initial reference to the primary purpose of the hospital.

(c) AFL suggests that the Board establish a reference point for average length of stay, such as "the most

recent twelve months preceding receipt of a representation petition for which data is readily available." We doubt that, with respect to this issue, individual hospitals will substantially vary depending on which 12-month period is utilized. However, for purposes of clarity, we shall revise the rule to encompass this suggestion.

(d) AFL further suggests that, where a petition is filed under the rule, and a hospital claims not to meet the definition of "short-term hospital," the burden should be on the hospital to produce the evidence, since the records would be in its sole control. The AFL is suggesting a *Tropicana*-type rule (*Tropicana Products, Inc.*, 122 NLRB 121 (1958)) for use in situations in which a hospital does not come forth with the necessary information. We trust this will not prove to be a major concern, since in the normal case it will be obvious whether a hospital is acute care or not; stipulations should usually be obtainable. However, in order to encourage the party in sole possession of the records to cooperate, we shall amend the proposed rule to provide that, where the employer does not, after issuance of a subpoena, produce records sufficient for the Board to determine the facts, the Board may presume the employer is an "acute care hospital."

(e) AFL urges the Board to reconsider and hold cases pending the effective date of the Final Rule. Alternatively, it urges the Board to use its new empirical knowledge and, for example, grant RN units even under the latest disparity of interests test. The same point is made, in more detail, by Comment 1710, American Nurses Association (ANA). The Board has not held cases pending the effective date of the Final Rule (see, e.g., Middletown Hospital Association, 291 NLRB No. 79 (Oct.

28, 1988)), although parties themselves may have refrained from bringing cases during this interim period; few have come to the Board since NPR II. Whatever the merits of the AFL's suggestion, and that of ANA, it is now moot.

(f) AFL suggests that, "to make the rule consistent with the preamble, it should state that a unit may be combined when petitioned for by a union. This would preclude an employer from arguing that only a combination unit is appropriate." That is, of course, the intent of this provision of the rule, as explained, with citations, in NPR II at 33932 (Sec. XIX, Combined Units). The long-standing principle of *Morand Brothers Beverage Co.*, 91 NLRB 409 (1950) (cited NPR II at 33932) continues to apply, and we shall make the required addition to the rule to clarify this point.

XI. Placement Decisions

Comment 1107, American Association of Nurse Anesthetists, asks for case-by-case consideration of whether certified nurse anesthetists properly belong in physicians' units or RN units. Such consideration will, of course, continue to occur, as the Board implied in NPR (at 25146, noting that some day in the future perhaps rulemaking would be utilized to determine unit composition), and NPR II (at 33926, stating "The precise placement of particular classifications which may be disputed in a particular case, is, for the time being, left to the case-by-case adjudicative approach.")

For the same reasons, we deny the request of American Society of Clinical Pathologists (Comment 1329) to

clarify the rule to specify that ASCP-certified medical lab technologists are to be included in "other professional" units, and certified medical lab technicians are to be included in technical units. The Board in this rulemaking proceeding at the outset disclaimed any intention to determine placement issues (NPR at 25146), and it would be inappropriate to deviate from this stated intention, even if the record were sufficiently complete to permit us to do so.

XII. Extraordinary Circumstances

AFL suggests that some of the limitations on the extraordinary circumstances exception set forth in the Supplementary Information accompanying NPR II (Section XX at 33932-3) be incorporated into the Final Rule. AFL suggest, e.g., that the rule should provide:

> Extraordinary circumstances exist only where a hospital is shown to be uniquely situated such that application of the rule would be accidental or unjust. Variations among acute care hospitals that were considered by the Board in promulgating this rule do not, alone or in combination, constitute an extraordinary circumstance.

AFL also asks that the rule make it clear that multi-site units are not an exception. The Board has considered these suggestions, but fails to see the necessary for including these matters in the Final Rule.

Several commenters suggest that the extraordinary circumstances exception is so narrow as to be useless

AHA argues that, because of the narrowness of the exception, parties would be deprived of due process. (Comment 1711.) However, the case cited for that proposition, *Jackson Water Works, Inc. v. Public Utilities Comm.*, 793 F.2d 1090, 1097 (9th Cir. 1986), merely states as a general proposition that "the due process clause guarantees an aggrieved party the opportunity to present a case and have its merits fairly judged (citations omitted). (S)ome form of 'hearing' is required before a person is deprived of a protected property interest." Aside from the question whether a constitutionally-protected "property" interest is involved when the Board makes a unit determination in a representation proceeding, it is clear that the hearing required by section 9(a) of our Act will continue to be available where the parties do not consent to an election. Supra, Section II, and, specifically, n. 2. We note, coincidentally, that the majority in *Jackson* held that the state's eminent domain procedure was constitutional, even though it provided for no right of appellate review. See also Comment 1330, Taft, Stettinius & Hollister. Comment 1087, California Association of Hospitals and Health Systems suggests that the extraordinary circumstances exception is so narrow that its inclusion is "a charade."

We do not agree with these commenters' characterizations. The purpose of the rulemaking procedure has been to gather a large amount of information, and then to set forth unit determinations consistent with the information gathered, appropriate for collective bargaining purposes, and consistent with the Board's obligations under the statute. The Board's experience since 1974, as documented in Board Exhibit 5, as amended, has been that, even under adjudication, with the facts of each individual

case recited in records of substantial length and expense, the Board has almost always reached the same result. That being true, avoidance of unnecessary litigation in each case has been one goal of the rulemaking undertaking. The extraordinary circumstances exception has had to be crafted in such a way as to satisfy due process by allowing for litigation where the circumstances warrant, i.e., are truly extraordinary – but at the same time precluding litigation where the arguments are merely repetition of matters already considered, such as the team approach, integration of functions, cross training, increased specialization, recent cost containment measures, etc.

We have, in this SUPPLEMENTARY INFORMATION, provided specifically for one "extraordinary circumstance," viz, a requested unit of five employees or fewer. There will undoubtedly be others, but we do not expect them to be frequent. We find nothing inconsistent with due process in the "extraordinary circumstances" exception crafted into the Final Rule. We reaffirm the scope of the extraordinary circumstances exception as set forth in NPR II.

XIII. Proliferation

A number of commenters dispute the Board's conclusions on proliferation in NPR II at 33933-94. Comment 1087. California Association of Hospitals and Health Systems, takes issue with the Board's analysis in NPR II, that Congress was concerned with patterns such as in newspaper and construction industries of fifteen or more units at a workplace. That commenter argues that Congress'

failure to specify a number does not justify the Board's speculation that eight units would satisfy Congressional concern. Comment 1330, Taft, Stettinius & Hollister, contends that the Board erroneously analyzed the legislative history. Taft, Stettinius believes that the parties did not reach a compromise whereby employers gave up statutory limitations on the number of units in return for stroke-restricting provisions; neither did unions win the right to use the five-unit specification as a floor. Comment 1686, American Society for Personnel Administration, contends that no other industry has as many units as the Board has given in this proceeding. Comment 1711, AHA, argues that the Board errs in believing that Congress merely wanted the Board to avoid patterning health care units after the newspaper or construction industries, stating that this argument was rejected by the Second Circuit in *Mercy Hosp. Assn.*, 606 F.2d 22, 27 (2d Circ. 1979), cert. den. 445 U.S. 971 (1980), which said that even application of the normal industrial unit criteria could impede effective delivery of health care services.

The subject of what Congress meant has been debated since 1974, with opinions varying from those expressed by the Board in NPR II, to those expressed by some courts as indicated above, to those expressed by Judge Edwards in *Electrical Workers IBEW Local 474 (St. Francis Hospital) v. NLRB*, 814 F.2d 697 (D.C. Cir., 1987) to the effect that varying expressions of Congressional intent are not legally binding upon the Board's since the statutory language was not changed.

We are inclined to agree with Judge Edwards that, since section 9(a) was not changed in 1974, varying expressions by legislators on what they intended do not

necessarily rise to a mandate requiring, for example, a disparity of interests standard.[8] Contrary to the understanding of The American Society for Personnel Administration, Comment 1686, it is not true that "with the limited exception of the construction industry, virtually no other industry covered by the NLRA must cope with as many as eight bargaining units." In industrial settings, there is the potential for far more than eight appropriate bargaining units. The following are but a representative sampling of the separate bargaining units found appropriate by the Board in various cases:

1. Drivers[9]
2. P & M (production and maintenance) employees[10]
3. Office clericals[11]
4. Guards[12]
5. Technical employees[13]

[8] Accord: Kilgour. The Health-Care Bargaining Unit Controversy: Community of Interest versus Disparity of Interest, 40 Lab. L.J. 81 at 92 (1989). See also *The D.C. Circuit Struggles With Standards of Reviewability*, 56 Geo. Wash. L. Rev. 960 (1988).

[9] *Memphis Furniture Manufacturing Co.*, 259 NLRB 401 (1961).

[10] *Comet Corp.*, 261 NLRB 1414 (1962).

[11] *Robbins & Myers*, 144 NLRB 295 (1963).

[12] *Bonded Armored Carrier*, 195 NLRB 346 (1972).

[13] *Local Corp.*, 200 NLRB 1019 (1972).

6. Driver-salesmen[14]
7. Toolroom employees[15]
8. Maintenance department employees[16]
9. Warehouse and service employees[17]
10. Patternmakers[18]
11. Electricians[19]
12. Welders[20]
13. Tool designers[21]
14. Crane operators[22]
15. Powerhouse employees[23]
16. Millwrights[24]
17. Attorneys[25]

[14] *Bardahl Oil Co.*, 163 NLRB 260 (1967).

[15] *McCulloch Corp.*, 189 NLRB 76 (1971).

[16] *Verona Dyestuff Div.*, 225 NLRB 1159 (1976).

[17] *A.B. Dick Co.*, 230 NLRB 257 (1977).

[18] *Mueller Industries*, 132 NLRB 469 (1961).

[19] *E.I. DuPont de Nemours and Co.*, 192 NLRB 1019 (1971).

[20] *Aerojet General Corp.*, 128 NLRB 313 (1960).

[21] *Douglas Aircraft Co.*, 157 NLRB 791 (1966).

[22] *Louisiana Industries*, 15-RC-2441, cited at 49 LRRM 1414 (1961).

[23] *American Can Co.*, 131 NLRB 909 (1961).

[24] *National Container Corp.*, 99 NLRB 1492 (1952).

[25] See *Westinghouse Air Brake Co.*, 121 NLRB 636 (1958). *Cf Legal Action of Wisconsin*, 261 NLRB 1095 (1985).

18. First-aid department employees[26]

19. Chemists, chemical engineers, and engineers[27]

20. Garment cutters and spreaders[28]

21. Industrial art designers[29]

22. Knitters[30]

23. Auto mechanics[31]

These twenty-three (there are at least as many more) potential units are, of course, unlikely to arise in any single establishment, just as it is unlikely that all eight potential appropriate units will occur in any given hospital[32]. In fact, based on our experience following the

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[26] *Ladish Co.*, 178 NLRB 90 (1969). And see *Westinghouse Air Brake Co., supra* (nurses).

[27] *Firestone Tire & Rubber Co.*, 181 NLRB 830 (1970). See also *Westinghouse Air Brake, supra.*

[28] *Benjamin & Jones*, 133 NLRB 768 (1961).

[29] *Chrysler Corp.*, 90 NLRB No. 265 (1950), not reported in Board volumes; reported at 26 LRRM 1415 (1950).

[30] *Morganton Full Fashioned Hosiery Co.*, 115 NLRB 1267 (1956).

[31] *Dodge City of Wau batosa*, 282 NLRB No.71 (1986).

[32] In Comment 1142, Bricker & Eckler alleges that attorney Roger King's testimony concerning other-professional units was taken out of context. It is alleged that King intended only to show that there was very little organizing among RNs in Ohio: i.e., such units exist in only 16 of Ohio's 180 private hospitals. However, King also testified that, in Ohio, only one separate other-professional unit exists (NPR II at 33908). We believe that King's testimony does support the conclusion for which it was cited, that in Ohio, the existence of separate units of RNs has not led to similar, separate units of all other professionals.

1974 health care amendments, we anticipate that most of the organizing will occur in RN units, technical units, skilled maintenance units, service and unskilled maintenance units, and, possibly, business office clerical units. Many physicians in hospitals are independent contractors, and there have been only one or two published cases involving separate physicians' units since 1974 (NPR, 52 FR 25147; NPR II, 53 FR 33905). Although a separate guard unit is mandated by the Act, we have had few if any hospital guard unit cases, perhaps because some hospitals contract out their guard service. The unit of all-other professionals is also required by the Act, if, as we have found, RNs and physicians constitute separate appropriate units; however, we have not had a large number of other professional units.

The original rulemaking record provided strong empirical support for all the units ultimately proposed in NPR II. In addition to the other factors mentioned in NPR II in support of the individual units, the separate labor markets for the RNs, skilled maintenance employees, and business office clericals favored separate representation for them. The legislative history showed "proliferation" was opposed by Congress because it was feared that would lead to numerous work stoppages, jurisdictional disputes, and wage whipsawing and leapfrogging. However, as was amply documented in NPR II, multiple units have not been shown to cause an unusual number of work stoppages, nor have they been shown to have caused jurisdictional disputes, wage whipsawing, or leapfrogging. Little additional evidence on these points was introduced during the current round of comments, except that several commenters expressed the view that,

since there have never, or rarely, been eight bargaining units in the health care field, the Board's evidence as to costs, strikes, bargaining success, and unionization is irrelevant. (See, e.g., Comment 1711, AHA; Comment 1081, Wausau Hospital. See also Comment 1044, Missouri Hospital Association, which argues that early units were recognized voluntarily because, prior to 1974, it was known that individual units could not strike.)

We do not agree that the evidence acquired during this proceeding is irrelevant. For one thing, even under adjudication, whether strikes, whipsawing, or jurisdictional disputes will result if an initial organizational effort succeeds carries with it a greater degree of speculativeness than is alleged here; under adjudication of individual cases, no evidence whatever can be adduced as to the facility under consideration, whereas, at least here, past experience in the industry generally can be and has been considered. The fact is that in the decade between 1974 and 1984 there were, generally, eight units recognized as appropriate under Board case law (including the statutorily-mandated separate unit of guards.) Despite continual uncertainty as to the proper standard, there was considerable organizational activity, and the evidence presented to us is that there were virtually none of the disruptive consequences which concerned Congress during the 1974 debates.

Comment 725, Greater Baltimore Medical Center, argues that, where there are existing units, more than eight may ultimately be found appropriate. While that is a theoretical possibility because section 103.30(c) of the rule technically removes such facilities from the literal reach of the rule, section XV of NPR II refers to the

principle of *Levine Hospital of Hayward*, 219 NLRB 327 (1975), which in effect prohibits residual or fractional units in health care facilities. The Board in NPR II deferred this issue to adjudication. Our stated intention will be, insofar as possible, to conform new units in such situations to the proposed rule.

As for the question whether the units found appropriate are too many, or proliferative, we do not believe that that was a question Congress wished us to answer in the abstract – as if, for example, "x" number of units are automatically proliferative, but "y" are not. Rather, we believe it has been incumbent upon us to carefully examine the exhaustive rulemaking record furnished by numerous parties from all sectors of the health care industry, and then to make a determination on appropriate units consistent with that evidence, consistent with our self-expressed desire to avoid a proliferation of units, and consistent with a requirement that these units not be likely to produce the unwanted results of repeated work stoppages, jurisdictional disputes, wage whipsawing, and other related evils. We believe we have done so and, for that reason, conclude that our determination is not unduly or reasonably proliferative in any meaningful usage of that phrase.[33]

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[33] We note that our unit determinations in this proceeding are not inconsistent with those in the cases cited with approval in the Senate Committee Report (S. Rept. 93-766, 93d Cong., 2d sess. 5 (1974)). Thus, in *Four Seasons Nursing Center of Joliet*, 208 NLRB 403 (1974), the Board found inappropriate a three-employee unskilled maintenance unit in a nursing home. Our rule does not cover nursing homes, and three-employee units are considered an "extraordinary circumstance" even in acute

(Continued on following page)

Our action in exempting units of five or fewer employees from the coverage of the rule is prompted by our concern about proliferation. Comments about the effects of a number of small units in small hospitals convince us that they could pose a serious proliferation potential. It is for that reason that we have excepted these small units from coverage of the rule. We note that the "small unit" exception is not limited to small hospitals. It could also have the effect of reducing the number of units in large health care institutions.

In addition to the foregoing, we continue to believe that Congress was concerned with the Board's not repeating the pattern of bargaining in such industries as newspapers and construction, and affirm those additional portions of NPR II which discuss this point.

(Continued from previous page)

care hospitals. In addition, maintenance employees who primarily empty trash, replace light bulbs, and move furniture are included in service units. In *Woodland Park Hospital*, 205 NLRB 888 (1973), the Board declined to find appropriate a separate unit of x-ray technicians. Our rule would, likewise, find inappropriate a separate unit of x-ray technicians. (The Board in *Woodland* did not have occasion to consider the appropriateness of an all-technical unit, since no request for review was filed to the regional director's ruling on that issue.) Finally, in *Extendicare of West Virginia, Inc., d/b/a St. Luke's Hospital*, 203 NLRB 1232 (1973), the Board found appropriate a separate unit of licensed practical nurses, but included the seven remaining technicals with the service and maintenance employees. Our rule would not find appropriate a separate unit of licensed practical nurses, who in prior Board cases have been found to be technical employees, but would rather group all technical employees together in a separate unit.

XIV. Regulatory Flexibility Act

No comments after NPR II addressed this issue. We reaffirm our prior certification. (53 FR 33934)

XV. Dissenting Opinion

Member Wilford W. Johansen dissents from establishing health care bargaining units through a rulemaking procedure.

In his view rulemaking in the health care industry is neither appropriate nor desirable, for several reasons.

He believes the language of the Act itself forecloses rulemaking for particular units. Section 9(b) of the Act requires that "The Board *shall* decide *in each case*" what the appropriate unit shall be, "in order to assure to employees the fullest freedom in exercising the rights guaranteed by" the Act. Under basic rules of statutory construction, he reads that language as mandatory rather than permissive. He also believes that the Board cannot satisfactorily fulfill its statutory obligation by relegating that specialized, decisional function to rulemaking procedures. Thus, while rulemaking is a desirable and even a necessary portion of the Board's functions in some areas, in his opinion, this is not one of those areas. It is important to remember that Congress did *not* amend section 9 when it enacted the Health Care Amendments in 1974. If Congress had intended that the Board abandon its then almost 40-year old decisional approach and instead embark on a wholly new procedure for determining appropriate units in portions of the health care industry (and only in that industry) it surely would have said so

explicitly. It did not do so; nor did it even implicitly suggest such action. The Board "rules" referred to by the majority as grounds for this action (i.e., *Excelsior* list, contract, bar, etc.) in his view simply do not support such a radical departure from well established precedent. They were themselves arrived at decisionally, and they did not involve unit determinations. Nor is he persuaded by reference to interpretation of different functions by other agencies.

Even assuming that abandoning the Board's decisional format for determining the appropriate unit in each case is a permissible exercise, however, he would not deem rulemaking with regard to health care units to be either necessary or desirable.

The disagreements between members of the Board or between one Board majority and another, have focused on questions concerning the meaning of the statute, analysis of the legislative history, and the interpretation of Congress' intent. The differences between the Board and various courts of appeals and the conflicts among the courts of appeals have involved not only those questions which divided the Board, but also issues concerning the proper scope of review, and the deference to be properly accorded to the Board's reading and interpretation of the Act – the Board's primary function and responsibility.

The appropriate procedure to resolve questions surrounding Congress' intent, the proper scope of review, and the Board's duty and authority in the exercise of its expertise under the statute, is to submit those questions to the Supreme Court, the final arbiter on issues of this nature. That is particularly true in this area, because the

Board has received criticism from Circuit Courts at both ends of the spectrum. Most of the disagreement has centered around application of the traditional "community of interest" standard versus a separate "disparity of interest" test for evaluating appropriate units in health care facilities. Different courts at different times have rejected each of these approaches. Thus, it seems especially appropriate to submit these issues to the Supreme Court to resolve the split in the circuit. That process best serves the interests of the parties, the general public, and the Board.

Other factors make the establishment of particular health care units through rulemaking at best inadvisable. Those courts that have deemed the Board's approach to health care units to be too rigid will continue to criticize such units established through rulemaking. And, because unit determinations established by a predetermined set of rules are inherently less flexible than those arrived at by decision in specific cases, it must be anticipated that criticism by some courts will intensify; on the ground that a result reached by the Board was not derived through application of its institutional expertise in a particular factual situation. Indeed, the Board must concede the validity of at least some such criticism. That is so not only because the rules themselves are less flexible, but also because the nature of the evidence on which the rule is based is in turn more generalized – primarily anecdotal and statistical – and, therefore, lacks the quality of pertinent evidence regarding a specific situation which lies at the core of the decisional process.

Another reason to reject the rule is the information which the Board has obtained during this process. As a

result of that experience, the Board has already seen fit to revise the proposed rules substantially. That fact in itself is a compelling reason to retain the Board's traditional decisional format, even if it were not required.

There have been considerable changes from one year to the next in this proceeding. Nursing homes and rehabilitation hospitals have been exempted from operation of the rule. The proposed "100-bed" distinction has been eliminated, along with the separate unit configuration for small hospitals. Thus, the number of proposed units affecting small hospitals has changed dramatically; and the number of units in large (now all) acute hospitals has been expanded by the addition of separate groupings for maintenance, and business office clerical employees. We do not know what will happen next year. Will the heavy burden of proof required under the "extraordinary circumstances" proviso virtually preclude evidence that the units established in this proceeding make little practical sense in a particular case? Will the Board need to indicate – again – that it might have proceeded differently if there had been more, or better, information when the rule was made? And, in that case, will the Board, the parties, and the public have to undergo another two year exercise in order to amend the rule to accord with what the Board then knows (or believes it "knows")? Such uncertainties neither benefit the Board nor any other constitutency. Certainly they do not effectuate the purposes of the Act.

For all these reasons, Member Johansen would vacate the notices of rulemaking and submit the issues to the Supreme Court for resolution.

List of Subjects in 29 CFR Part 103

Administrative practice and procedure, Labor management relations.

Regulatory Text

For the reasons set forth at 52 FR 25142-25145 (through Section IV), and also 53 FR 33900-33934, as supplemented and modified by this Supplementary Information, 29 CFR Part 103 is amended as follows:

PART 103 – OTHER RULES

1. The authority citation for 29 CFR Part 103 is revised to read as follows:

Authority: 29 U.S.C. 156, in accordance with the procedure set forth in 5 U.S.C. 553.

2. Subpart C, consisting of § 103.30, is added to read as follows:

Subpart C – Appropriate Bargaining Units

§ 103.30 Appropriate bargaining units in the health care industry.

(a) This portion of the rule shall be applicable to acute care hospitals, as defined in paragraph (f) of this section: Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for petitions filed pursuant to

section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that, if sought by labor organizations, various combinations of units may also be appropriate:

(1) All registered nurses.

(2) All physicians.

(3) All professionals except for registered nurses and physicians.

(4) All technical employees.

(5) All skilled maintenance employees.

(6) All business office clerical employees.

(7) All guards.

(8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards. *Provided That* a unit of five or fewer employees shall constitute an extraordinary circumstance.

(b) Where extraordinary circumstances exist, the Board shall determine appropriate units by adjudication.

(c) Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed pursuant to sec. 9(c)(1)(A)(i) or 9(c)(1)(B), the Board shall find appropriate only units which comport, insofar as practicable, with the appropriate unit set forth in paragraph (a) of this section.

(d) The Board will approve consent agreements providing for elections in accordance with paragraph (a) of

this section, but nothing shall preclude regional directors from approving stipulations not in accordance with paragraph (a), as long as the stipulations are otherwise acceptable.

(e) This rule will apply to all cases decided on or after May 22, 1989.

(f) For purposes of this rule, the term:

(1) "Hospital" is defined in the same manner as defined in the Medicare Act, which definition is incorporated herein (currently set forth in 42 U.S.C. 1395x(e), as revised 1988);

(2) "Acute care hospital" is defined as: either a short term care hospital in which the average length of a patient stay is less than thirty days, or a short term care hospital in which over 50% of all patients are admitted to units where the average length of patient stay is less than thirty days. Average length of stay shall be determined by reference to the most recent twelve month period preceding receipt of a representation petition for which data is readily available. The term "acute care hospital" shall include those hospitals operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, psychiatric care, or rehabilitative care, but shall exclude facilities that are primarily nursing homes, primarily psychiatric hospitals, or primarily rehabilitation hospitals. Where, after issuance of a subpoena, an employer does not produce records sufficient for the Board to determine the facts, the Board may presume the employer is an acute care hospital.

(3) "Psychiatric hospital" is defined in the same manner as defined in the Medicare Act, which definition is incorporated herein (currently set forth in 42 U.S.C. 1395x(f)).

(4) The term "rehabilitation hospital" includes and is limited to all hospitals accredited as such by either Joint Committee on Accreditation of Healthcare Organizations or by Commission for Accreditation of Rehabilitation Facilities.

(5) A "non-conforming unit" is defined as a unit other than those described in paragraphs (a)(1) through (8) of this section or a combination among those eight units.

(g) Appropriate units in all other health care facilities: The Board will determine appropriate units in other health care facilities, as defined in section 2(14) of the National Labor Relations Act, as amended, by adjudication.

Dated, Washington, DC, April 18, 1989.

John C. Truesdale,
Executive Secretary.
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